National Child and Adolescent Mental Health Service Mapping Exercise 2004

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foreword

This is the third National CAMHS Atlas to be published, summarising information from specialist Child and Adolescent Mental Health services across England submitted November 2004. Continued thanks to all those who provided data and to the team in Durham who handled people's queries and collected the vast quantity of information.

This is a new look atlas this year to respond to the publication of the National Service Framework for Children, Young People and Maternity Services in September 2004. In order to support local implementation as far as possible the atlas has been reorganised alongside the elements of a comprehensive CAMHs and the markers of good practice as set out in Chapter 9 of the CNSF.

It is a credit to all those involved in its development that when the scope of the mapping exercise was agreed four years ago, it had predicted many of the key service issues that are set out in the CNSF. The mapping exercise therefore captures complementary data that helps to monitor progress against national policy and to support local implementation.

In addition you will see that it has become far more user friendly, with graphs, maps and pie charts replacing old and often 'dry' lists of figures in tables. Your feedback on this new format would be welcomed by the team.

The atlas emphasises the significant progress that has been made in the delivery of national targets across services in England over the last three years. Good news stories include the increase in on-call provision, improvements in service coverage up to 18 years by locality teams, a slow but gradual increase in learning disability services and 15%, and 20% increases in staffing and activity respectively. Significantly, there was also an 18% real rise in investment in CAMHS and most of this is being spent with specialist CAMHS providers.

These are of course national trends with significant local variations. The mapping exercise would be pointless if it were not used locally to inform service development. There is increasing evidence through the National CAMHs Support Service and directly from the field that there is better understanding of the value of this exercise in helping inform local planning and decision-making.

The Durham team hope to encourage increased use of the data at local level by a new on-line facility that will generate most of the graphs included in this document on a locality basis. Details of this will follow this publication and will be found on www.camhsmapping.org.uk.

For those short of time, Chapter 1 represents an excellent summary of the document and this will be published as a separate pamphlet alongside the atlas for easy reference.

I fully commend this document to all of those interested in the current status and the development of child and adolescent mental health services.

My thanks once again to all of you involved in making this a success.

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National Clinical Director for Mental Health
DEPARTMENT OF HEALTH

Introduction

Overview

This report presents the results from the third national Child and Adolescent Mental Health Service (CAMHS) mapping exercise carried out between October 2004 and February 2005. The purpose of the work was to continue the inventory of specialist CAMHS provision that began in 2002. While it is acknowledged that many individuals, including teachers, social workers and GPs, make important contributions to promoting the mental well being of children in jobs that are not specifically designated as mental health care, it is not within the remit of this exercise to map this complex network of support, often referred to as Tier 1. The mapping focuses on Tier 2-4 services as defined in the Health Advisory Service's report, Together We Stand (1995) and expanded upon in Children in Mind (1999) and the 2004 National Service Framework for Children, Young People and Maternity Services (CNSF) [set out in annex 1].

Aims

The CAMHS mapping aims to:

- support the development of the CNSF and help provide a focus on specialist CAMHS provision
- support the commissioning of CAMH services by providing a description of service provision
- assist in the bid for resources for CAMHS development
- support local service development
- provide comparative data on the progress in achieving service frameworks and delivery plan targets, for the range of inspectorial and performance management bodies.

The CAMHS Mapping exercise provides a national view of what services are provided, where and in what quantity. Initially, it was a large undertaking but as the process has become established, services have become familiar with the contribution required of them. This year, near universal coverage has been achieved. This third round of data collection was the second to be completed entirely on the internet. Services were able to build on the data submitted the previous year instead of starting from scratch. This enabled errors to be corrected and omissions made good as well as new growth to be mapped for the first time.

The mapping team do everything in their power, within the resources available, to ensure that the data are accurate. However the exercise is complex, involving large numbers of reporters around the country. Inevitably this means there is some room for variation in the interpretation of guidance and definitions (however precise), as well as for simple mistakes. A lot of work goes into checking for these and consulting local services to verify or correct surprising data. But data on this scale are unlikely to be perfect and should always be used with critical circumspection. However, they are also indispensable as a starting point. The regular collection and examination of these sorts of service provision details is the only possible evidential basis for steering a course to achieve uniform access for people at equal levels of need.

Management Arrangements

CAMH service mapping was undertaken by the Centre for Public Mental Health at the University of Durham. The Durham Mapping Team have undertaken mapping of mental health services for working-age adults for the last 5 years and has recently begun mapping mental health services for older people and wider children's health services. CAMHS mapping was developed in partnership with the CAMHS policy branch at the Department of Health and the Durham team continues to work in close collaboration with the Department of Health (DH), Department for Education and Skills (DFES) and the National CAMHS Support Service. The exercise is advised and approved by a National Advisory Group of practitioners, managers and policy makers who provide a wide representation of agencies and disciplines in the CAMHS field. Advice was also obtained from the field from an operational group and email discussion group. The Review of Central Returns (ROCR) at the Department of Health approved the exercise. (Reference: CAMHS Mapping SUB 204-107).

Methodology

A detailed description of the mapping process and quality checks undertaken is provided in Chapter 6 but, in brief the key stages are as follows:

Within each NHS trust providing CAMHS tier 2-4 teams, a Head of Service (HoS) was appointed to take responsibility for collecting the data on the services provided in their area. First, HoS were asked to register on the mapping website and identify the catchment/partnership area to which they provide local CAMH services.

HoS were required to identify:
1. Who commissioned the service?
2. What tier 2-4 teams were provided by the trust and its partners?

HoS ensured that all commissioners of the services mapped were informed of the mapping exercise and had access to the website but commissioners themselves were responsible for returning budget information. For Primary Care Trusts (PCTs) and NHS Trusts these data contribute to 2005 Balanced Score Card performance measures.

For all teams delivering tier 2-4 CAMHS, details of their provision, function, specialisation, staffing and activity were requested. Some details of the characteristics of the children and young people with whom CAMHS staff worked were also collected. All data were reported through an online database, although the website provided printable documents which could be used to collect the information in the first instance if local information systems were inadequate.

A wide range of checks were built into the website through which data were reported. Postcompletion checks were also undertaken by the Durham Mapping Team in the course of preliminary analysis.

Finally, chief executives 'signed-off' the data, indicating that, in the view of the Trust, it was complete. HoS were given four weeks from the end of the period scheduled for data inputting to the final sign-off of data to check, correct and confirm that what they were reporting was accurate.

The database was frozen on 28th February 2005 after which time no further changes could be made. Data on investment, staffing and activity numbers which were required for the NHS Trust and PCT performance measures were provided for the Healthcare Commission at this stage.

A helpdesk operated throughout the mapping period and could be contacted by phone, email or through an online discussion board.

Terminology

Definitions of the terms used in the Atlas are provided in the relevant chapters but special note should be taken of terms used to describe teams as there are two important distinctions. CAMHS teams are usually described within the tier 1 - 4 typology. However, in the development of the CAMHS mapping, it was found that the tier system was not enough to denote the structure and function of the teams and so a team type was created to provide a short-hand team descriptor. The types that evolved from the pilot and first CAMHS mapping exercises were: generic teams (both multi and single discipline); targeted teams; dedicated CAMHS worker teams; and special care teams. Broadly, the first three team types equate to tiers 2/3 and special care teams equate to tier 4. As the activity of tier 4 teams has been collected differently from the rest – again in response to feedback from the field during the first 2 mapping exercises – it is not always possible to report 'all teams' together. Therefore, when activity is reported, tier 2/3 teams has been described separately from tier 4 teams.

The second way that CAMHS teams have been described is to identify local teams and those that serve a wider-than-local catchment area, which may be a number of Strategic Health Authority (SHA) areas or even the whole country. This distinction is important as CAMHS policy is stressing the need for local integrated care for children and young people in which partner agencies work together to meet local need as close to where people live as possible. However, there is not a complete match between tiers 2-4 and local and wider teams. The match is good between local and tier 2/3 teams with 96% falling into both categories but for wider than local teams the match is poor. Only 56% of wider teams are also tier 4 teams, the other 44% (59 teams) are described as tier 2/3. Therefore within the Atlas, the two parallel ways of describing CAMHS teams are used.

Using this atlas

Following the publication of the Children's National Service Framework, the mapping atlas has been restructured to support the implementation of this significant child policy. This structure will not change for the life of the CNSF and should indicate to managers and clinicians the extent to which their SHA is delivering the Public Sector Agreement targets, including performance indicators for staffing, investment and activity and the delivery of a comprehensive CAMH service.

In more detail:

Chapter 1:	sets out the key national messages against each of the aspects of CAMHS. It serves as an executive summary for which policy makers and managers should derive key national messages.
Chapter 2:	sets out the elements of a comprehensive CAMH service mapped by these examples such as team types, on call, learning disability services and 16-18 year services.
Chapter 3:	sets out the national progress against the performance indicator on spend.
Chapter 4:	sets out the national progress against the performance indicator on activity.
Chapter 5:	sets out the national progress against the performance indicator on workforce.
Chapter 6:	discusses the technical aspects of the exercise including quality checks.

Local access to data

This is a national atlas reporting data at a Strategic Health Authority / National level only. For local CAMHs partnerships to utilise this information constructively they should use the CAMHS mapping website to explore and download data at a trust level. Web based reports are being developed in a number of formats and will include the facility to examine the data from a PCT and LA commissioning perspective. Guidance on the use of these reports will be available online. If you have any difficulties, please contact the team.

The website can be found at: www.camhsmapping.org.uk/2004 and the Mapping Team can be contacted at: help@camhsmapping.org.uk

Note on accuracy

This atlas presents the most accurate possible picture at the time of going to press. In a few cases errors came to light after the data for the Healthcare Commission had been finalised. Where there are differences these represent corrections.

Chapter 1:
A Summary of National Trends

This chapter summarises the key national messages obtained from the 2004 National CAMHS mapping exercise and serves as a useful executive summary. It contains the following sections:

Detailed tables of the data used to produce the tables used here can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2004

1.1 Registered Services

- 139 services returned mapping data, an increase of 6.9% from 130 services reporting in 2003.
- 4 of the services were new to the mapping and changes to the way localities mapped CAMHS provision was reported in 7 other areas. The principal reason for the changes was due to large specialist mental health NHS trusts reflecting the development of local CAMHS partnership arrangements. For example, instead of returning a single return for the whole trust area, these trusts submitted a number of 'service' returns, each referring to specific localities which were co-terminous with specific partner PCTs and local authorities.

1.2 Team development

- The number of teams mapped increased from 905 teams in 2003 to 989 in 2004, an increase of 9.3%.
- The number of local teams reported increased from 801 in 2003 to 854 in 2004, an increase of 6.6% (Fig 1.2a).
- Teams that were wider than local increased from 104 in 2003 to 135 in 2004, an increase of 30%.
- Of the 989 teams mapped, 751 (76%) were as mapped the previous year (Fig. 1.2b). 99 teams (10%) were newly resourced and had been set up since 2003. A further 51 teams (5%) were new to the mapping but were not new on the ground. 34 teams (3%) were mapped differently reflecting reconfiguration of local resources, while the mapping of 54 teams (5%) was changed to improve the accuracy of the data recorded.
- The proportion of newly resourced local and wider teams was 11% and 7% respectively.

Fig. 1.2a: Trends in local and wider teams

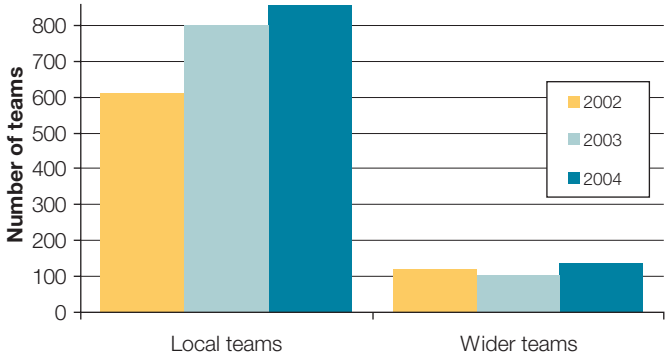
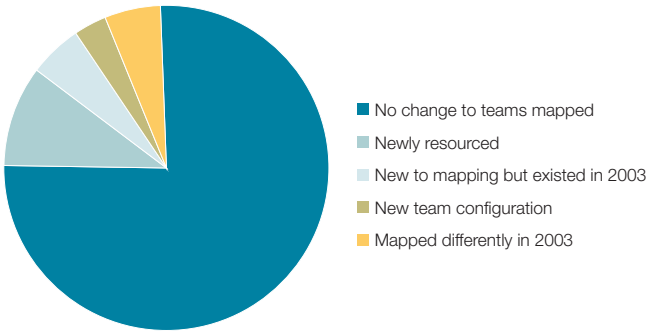


Fig. 1.2b: Changes to the teams mapped 2003 to 2004

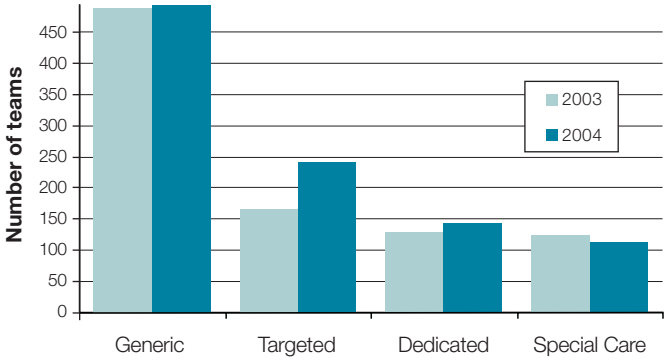


1.3 Comprehensive CAMHS provision

1.3.1 Team Types

- Specialist CAMHS provision has grown to meet the diverse needs of children and young people. Growth can be seen in the number of targeted teams and dedicated workers located in non specialist CAMHS teams (Fig. 1.3a).

Fig. 1.3a: Trends in team type



- Staff numbers in generic teams, both multi-disciplinary and single discipline, has increased by 1,107 WTE (26%) although the number of generic teams has grown by only 4 teams overall (Fig. 1.3a & b).
- Staffing in targeted teams increased by 22% and this represents the largest growth between the four team types. 43% of teams receiving new investment were targeted teams (Fig 1.3c).
- 30% of newly resourced provision was in dedicated CAMHS staff working in nonspecialist CAMHS teams, such as Youth Offending Teams (YOTs) and Behavioural and Educational Support Teams (BESTs). The overall drop in staffing in dedicated teams was due in part to improved accuracy in the mapping (non-CAMHS staff that were mapped in error in 2003 were removed) and partly due to the development of targeted teams.
- There was only a small growth in tier 4 teams during 2004. Staffing increased by 4%, and only 8% of new investment was made in this area of provision (Fig. 1.3c).

Fig. 1.3b: Trends in team type staffing

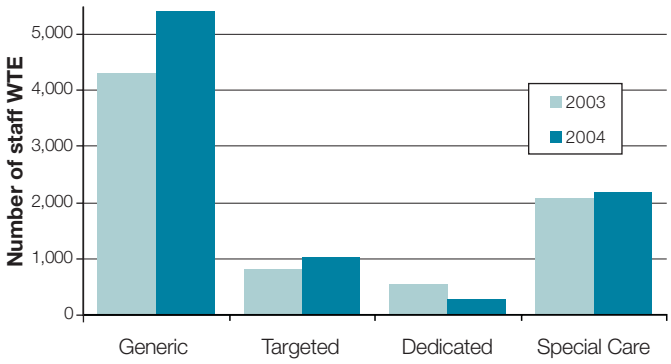
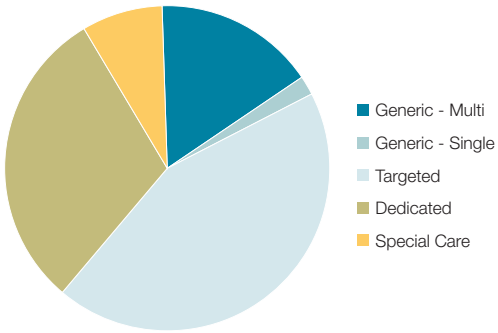


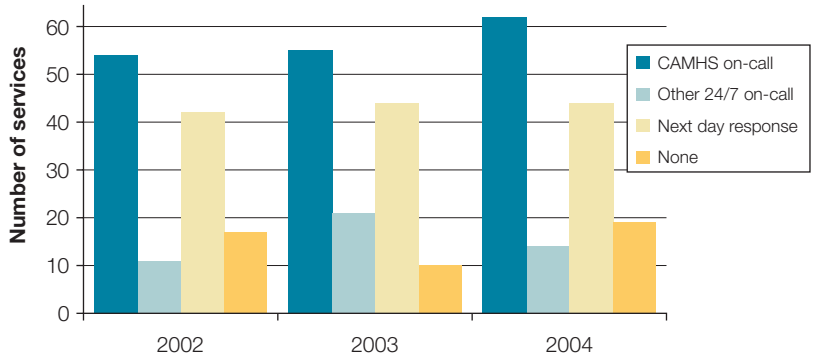
Fig. 1.3c: Type of teams newly resourced in 2004



1.3.2 On-call Provision

- The number of CAMH services with on-call provision that provide a response by CAMHS professionals increased from 55 services in 2003 to 62 services in 2004 (Fig. 1.3d). This represents 45% of the 139 CAMH services mapped providing this type of on call service.
- Overall, there were 78 on-call services mapped, an increase of 4 from 2003. However, because of the increased number of services registered, the percentage of services with on-call decreased from 57% in 2003 to 56% in 2004.
- The number of services which did not have an on-call service but did provide next day emergency response by CAMHS professionals remained static at 44 services.
- 19 services were found to have no on-call and no emergency next day response by CAMHS staff.

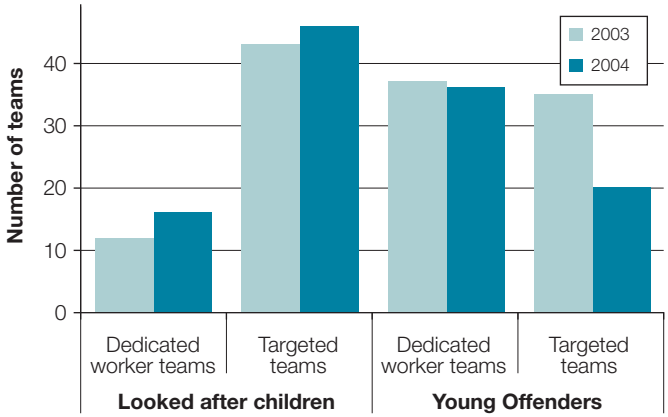
Fig. 1.3d: Trends in CAMHS on call provision



1.3.3 Learning disabilities services

- The number of services which reported specialist provision for children and young people with both learning disabilities and mental health problems rose from 44 in 2002 and 48 in 2003, to 62 in 2004. There has been considerable investment in these specialist services in the last 12 months.
- The number of learning disabilities cases was 8,764 representing 8% of the total caseload during the mapping period.

Fig. 1.3e: Trends in focus on looked after children and young offenders



1.3.4 Services for looked after children

- The number of CAMHS teams providing a focus on looked after children increased in 2004. More generally 46 targeted teams and 16 dedicated worker teams reported a focus on social services work (Fig. 1.3e).
- A total of 8,448 looked after children were cared for by CAMH services during the mapping data collection period, again representing about 8% of the total caseload. 574 looked after children were on the caseload of CAMHS tier 4 teams.

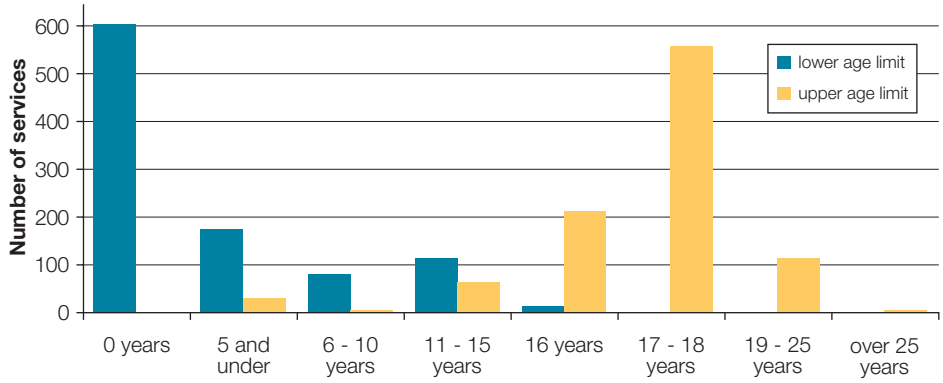
1.3.5 Services for young offenders

- 5173 young offenders received care from CAMH services, representing 5% of the total caseload.
- 8% of targeted teams and 25% of the dedicated CAMHS workers working in non-CAMHS teams were focussed on young offenders. The number of targeted teams supporting offenders fell by 43% (Fig. 1.3e). This is partly explained by increased accuracy in reporting since in the past mappers had counted the entire resource of youth offending teams, a national initiative with a broader remit than CAMHS established through the Home Office, rather than only the specialist CAMHS resource often employed to work within or alongside these teams to support this wider function.

1.3.6 Services for 16 to 18 year olds

- 26% of the caseload of tier 4 teams and 14% of the caseload of tier 2/3 teams were aged 16 to 18 - a total of 12,038 individuals. This represented 12% of the total caseload.
- 888 teams (90%) had an upper age limit of 16 or over. 101 teams (10%) had an upper age limit of 15 or below. 558 teams (56%) had an upper limit of 17 and 18. 119 teams (12%) had an age limit above 18 (Fig. 1.3f).
- 466 (95%) of generic teams had an upper age limit of 16 or over.

Fig. 1.3f: Upper and lower age limit of CAMHS provision

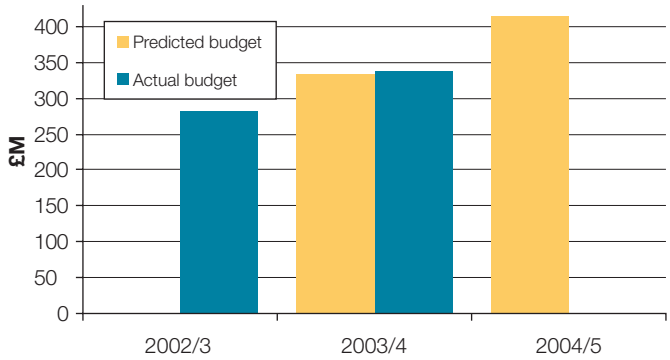


** Although there is a target for CAMHS teams to work with 16 and 17 year olds, not all CAMHS teams work with children of this age, for example, pre-school teams.*

1.4 Investment in CAMHS

- Reported spend on CAMHS increased by 23% between the financial years 2003/4 and 2004/5. The increase the previous year was 18% (Fig. 1.4).
- Actual spend on CAMHS was £353,378k in 2003/4. The predicted spend in 2004/5 was £416,303k.
- The commissioning budget of PCTs was £278,387k in 2003/4 rising to £337,625k in 2004/5, an increase of 21%.
- The local authority budget for commissioning CAMH services was £59,238k in 2003/4 rising to £61,307 in 2004/5, an increase of 3%.
- Government initiatives accounted for 3% of the total CAMHS budget. In 2003/4, £10,796k and in 2004/5 £14,338k came from these sources.
- Spend per child was £30.7 in 2003/4 but this had risen to £37.6 in 2004/5.
- Adjusting to 2004/5 prices, using the PSSRU hospital and community services pay and prices index*, the actual spend on CAMHS £352,543k. In 2004, accounting for inflation the increase in investment from 2003/4 to 2004/5 was 18%.

Fig. 1.4: Predicted and actual spend on CAMHS 2003-2005



**Personal correspondence from Curtis L, PSSRU, University of Kent, Canterbury.*

1.5 Activity

1.5.1 Caseload Numbers

- Total caseload of services recorded in the 2004 mapping was 104,744, an increase of 21% from the 2003 caseload of 86,521 (Fig.1.5a).
- The number of new cases seen in the data collection period in 2004 was 27,875, a rise of 70.5% on the 18,362 new cases seen in 2003.
- The high increase in caseload occurred mainly in established CAMHS teams suggesting that new staff mapped in 2003 and the staff now employed at the tier 1/2 interface have significantly increased the number of referrals that teams can respond to. However, some of the increase is likely to be due to improved data capture.

1.5.2 Waiting Times

- 14,117 of the new cases (51%) had waited 4 weeks or less and an additional 8,671 cases (31%) waited less than 3 months (Fig. 1.5b).
- The number of cases that had waited up to 6 months showed an increase but this was because the number of new cases seen had risen (Fig. 1.5b).
- The overall percentage of cases waiting 3-6 months fell from 14% of new cases on 2003 to 11% of new cases in 2004. Similarly, the number of new cases that had waited over 6 months rose slightly but the overall percentage waiting this long fell from 9% to 8%.
- At the end of the 2004 data collection period there were 30,716 cases still waiting, compared to 28,880 in 2003. This reflected higher demand for services as the number of cases waiting for up to 4 weeks and 3 months had slightly increased and the numbers waiting 3-6 months had decreased.

Fig. 1.5a: Trends in cases seen and waiting

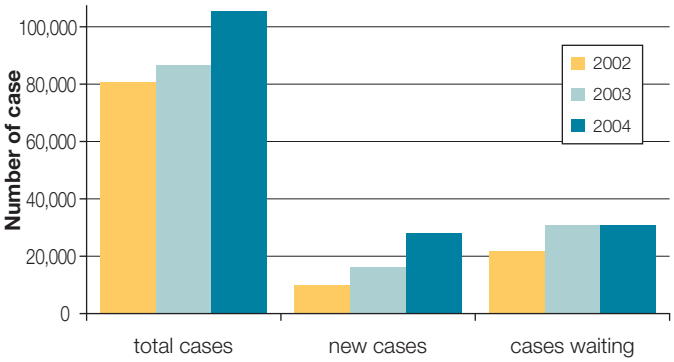


Fig. 1.5b: Trends in cases and length of wait

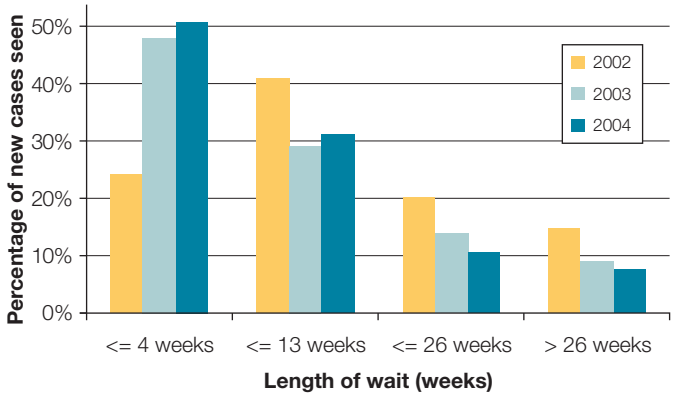
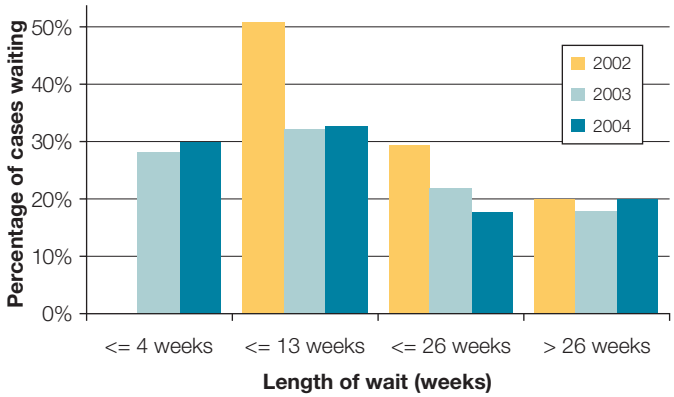


Fig. 1.5c: Trends in length of wait of cases still waiting

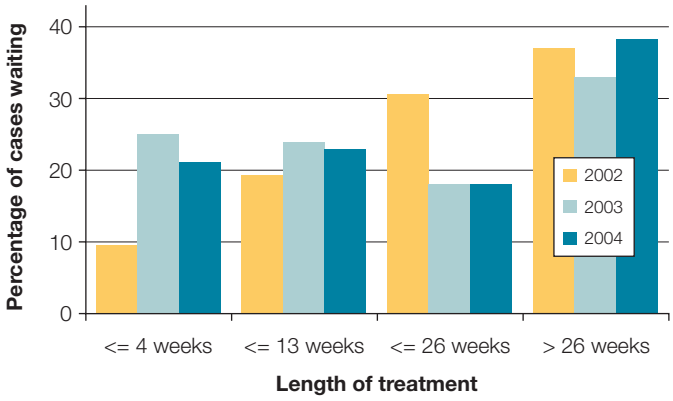


NOTE: In 2002, the shortest wait recorded was < =13 weeks

1.5.3 Length of Treatment

- There is evidence that the length of treatment provided by CAMHS teams is increasing (Fig. 1.5d).
- 39% of the caseload were waiting longer than 26 weeks

Fig. 1.5d: Trends in length of treatment



1.5.4 Age profile

- The age profile of the caseload shows an increase in the percentage of older children seen by tier 4 teams, a decrease in the proportion of children seen aged 5-9 and no change in the proportion of pre-school children seen in the services (Fig. 1.5e and f).

Fig. 1.5e: Trends in age of CAMHS caseload in tier 2/3 teams

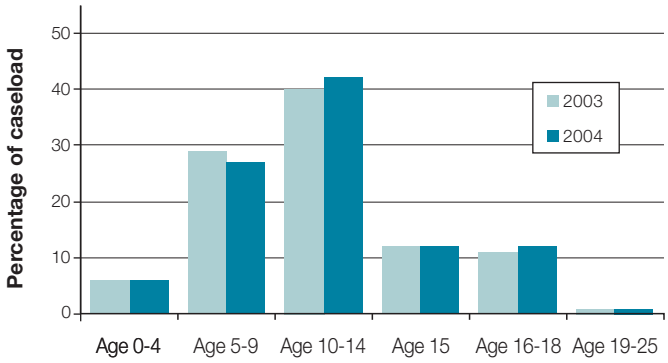
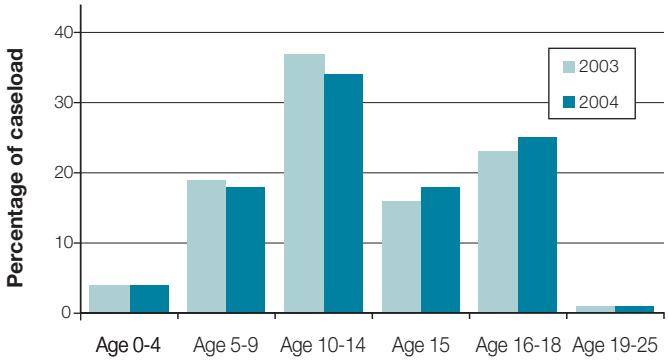


Fig. 1.5f: Trends in age of CAMHS caseload in tier 4 teams



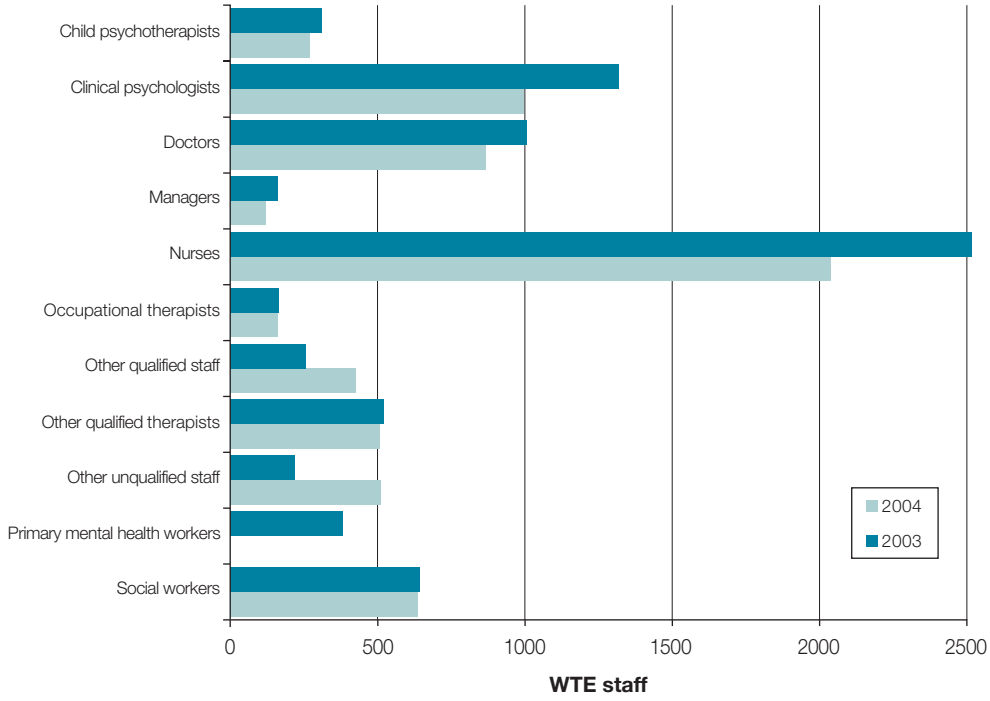
1.5.5 Ethnicity

- 81% of the children and young people using CAMHS teams were of white British origin. The proportions of cases from Black and minority ethnic communities were 3% Asian, 3% black African, Caribbean and black British, 4% of mixed race and 1% other. In only 7% of cases no ethnicity was recorded, a significant improvement on previous years.

1.6 Workforce

- The total number of staff employed in CAMHS teams increased from 7,761 in 2003 to 8,894 in 2004, a growth of 14.6%.
- The largest reported growth was in the number of clinical psychologists. Their workforce grew from 997 in 2003 to 1320 in 2004, an increase of 32.4% (Fig. 1.6). This is likely to have arisen partly from a genuine increase in numbers (due to the increase in training places nationally) but also in part from improved recording as clinical psychologists employed through non-specialist mental health providers are increasingly being included.
- The nursing workforce increased from 2,037 in 2003 to 2,517 in 2004, an increase of 23.5%.
- Primary Mental Health Workers were mapped for the first time in 2004 and 362 were recorded.

Fig. 1.6: Trends in age of CAMHS caseload in tier 2/3 teams



Chapter 2:

Aspects of comprehensive CAMHS provision

This chapter summarises information provided in the 2004 mapping on the provision of a comprehensive CAMH service. It includes sections on:

Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2004

2.1 Types of CAMHS tier 2 to 4 provision

Child and adolescent mental health professionals provide a balance of direct and indirect services and are flexible about where children, young people and families are seen in order to improve access to high levels of CAMHS expertise.

(NSF for Children, Young People and Maternity Services 2004 –Standard 9: Markers of good practice p.5.)

A total of 989 CAMHS teams were mapped in 2004, an increase of 9.3% from 905 teams in 2003. To capture the range of work undertaken, the teams were categorised into 5 types. Half of the teams were generic (Fig. 2.1a). These provide the backbone of specialist CAMH services ensuring a range of therapeutic interventions are available to children, young people and families locally. The majority of these teams (86%) were multi-disciplinary which means that they were staffed by a range of CAMHS professionals. The remaining 14% of generic teams were staffed by a single professional group such as clinical psychologists or social workers.

Almost a quarter of teams (24%) were targeted focusing on meeting the specific needs of children and young people such as the mental health needs of children looked after. 14% of teams were dedicated workers. These are CAMHS professionals who provide specialist mental health input in teams which have related focus such as education or community paediatrics.

11% of teams were Tier 4 provision. These provide intensive support through in-patient, day care or intensive home support of various kinds. Almost 24% of the CAMHS workforce is employed within Tier 4 teams (Fig. 2.1b). Note that in previous mapping exercises, this group were described as special care teams.

Team type definitions

Generic teams: Generic CAMHS teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area.

Generic (multi) teams: These are made up of CAMHS professionals from a number of disciplines who work together to ensure integrated provision.

Generic (single) teams: These are single-disciplinary groups of staff who provide a range of therapeutic interventions.

Targeted teams: These teams provide for children with particular problems or requiring particular types of therapeutic intervention.

Dedicated worker teams: Dedicated workers are fully trained CAMHS professionals who are out-posted in teams that are not specialist CAMHS teams but have a wider function, such as a youth offending team or a generic social work children's team.

Tier 4 teams: These services provide longer term or more intensive provision. This may take the form of whole- or half-day activities, inpatient care, or outreach support (such as emergency or after care) which is considered an alternative to in-patient care. Some may provide more than one of these types of care.

Fig. 2.1a: Types of Team (N=989)

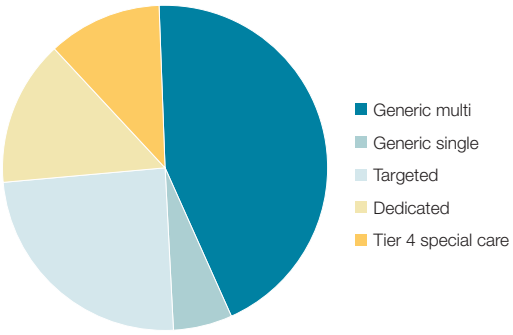
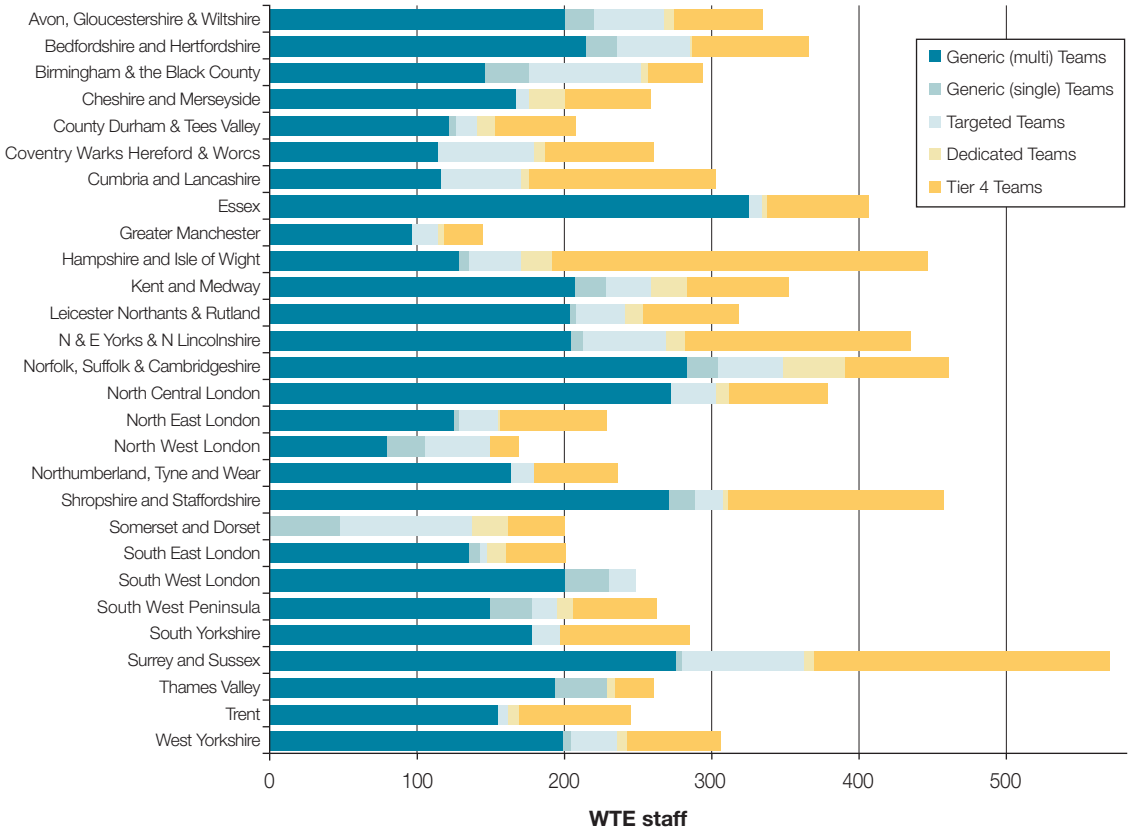


Fig. 2.1b: Staffing WTE by team type (N=8892)



2.2 Generic teams

In 2004, 492 generic teams were identified. This was only a slight increase from the 488 reported in 2003. However, the workforce in generic teams rose by 26% from 4,306 WTE in 2003 to 5,410 in 2005 indicating consolidation and substantially increased investment.

For the first time, in 2004, a distinction was made between generic teams employing a range of CAMHS professionals and those providing a single professional focus. 433 of the generic teams were multiprofessional providing generalist CAMHS provision to a locality.

There were 59 single disciplinary generic teams. The most common professional discipline involved was clinical psychology which accounted for 43 of the teams (Fig. 2.2a). The remaining teams describe themselves as psychiatry (4 teams), education (1 team) and infant mental health (1 team). Although most adolescent services are provided in generic multi-disciplinary teams, 7 were provided within singlediscipliinary teams.

The majority of generic teams were located in the community (Fig. 2.2b & c). Overall, 70% of multidisciplinary generic teams were community based and 47% of single disciplinary teams. Hospitals were the setting for 20% of generic (multi) teams and 36% of generic (single) teams. Other settings included GP clinics, social services, education establishments and voluntary agencies.

Fig. 2.2a: Focus of generic teams (multi and single discipline) (N=492)

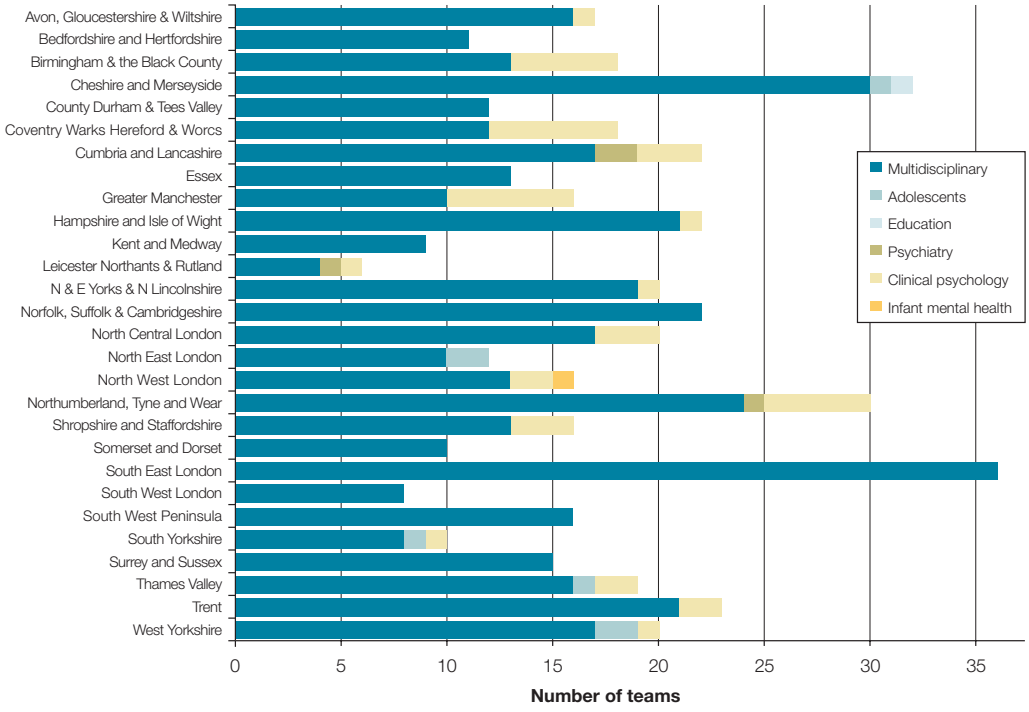


Fig. 2.2b: Location of multi-disciplinary generic team (N=433)

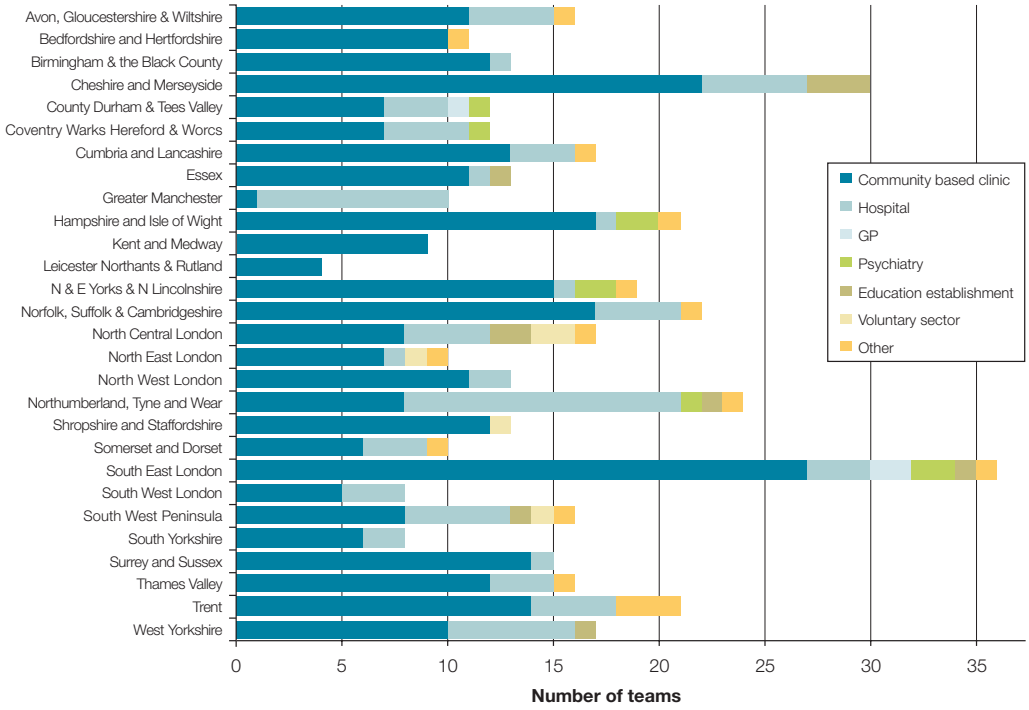
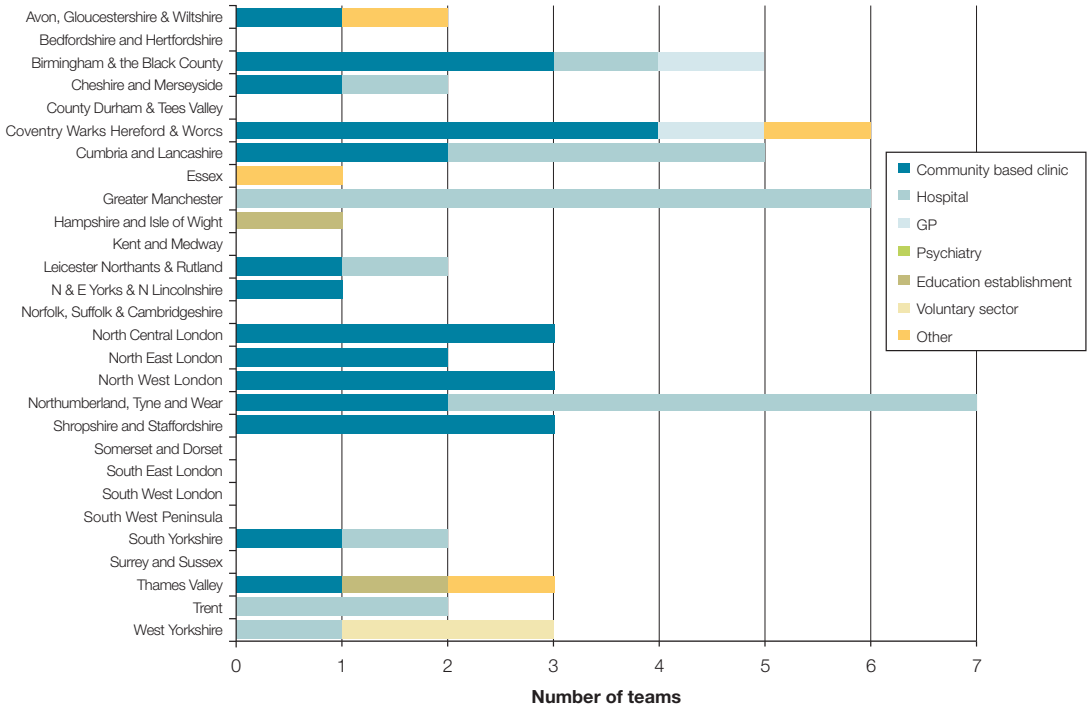


Fig. 2.2c: Location of single discipline generic teams (N=59)



2.3 Targeted teams

2004 saw considerable growth in the number of targeted teams. The number of teams grew from 167 in 2003 to 240 in 2004. The workforce increased from 809 WTE in 2003 (10.4% of the CAMHS workforce) to 1,035 WTE (12% of total CAMHS staff).

Change was also seen in the focus of the targeted teams mapped. In an attempt to reduce the number of teams recording a focus of 'other', the number of target categories was increased but this strategy was only partially successful. The number of teams with an 'other' focus increased from 86 in 2003 to 96 in 2004 although the proportion of teams concerned decreased from 51% in 2003 to 40% in 2004.

The most common foci for targeted teams were: social services, including looked after children (46 teams); learning disabilities (32 teams); young offenders (14 teams); paediatric liaison and substance misuse teams (14 teams each). These and other foci are shown in Fig. 2.3a.

The very scattered distribution of targeted teams can be seen in Fig. 2.3b.

The location of targeted teams depended a little on the focus of the team. 80% of teams were located in community clinics, hospital or social services settings. 7% of teams were located in educational establishments and 3% in voluntary agencies. The variation in provision is apparent in Fig. 2.3c.

Fig. 2.3a: Focus of targeted teams (N=240)

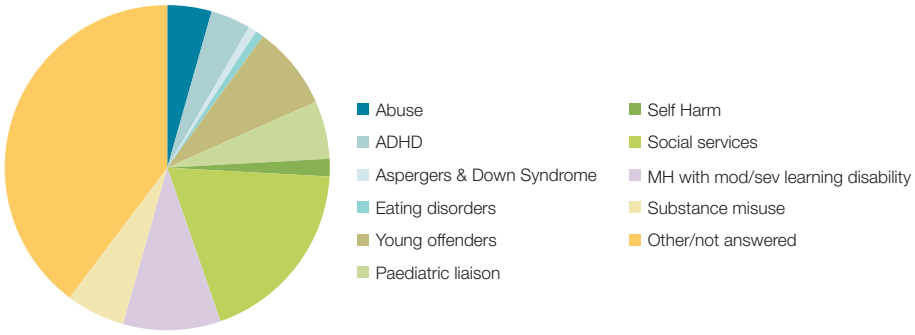


Fig. 2.3b: Focus of targeted teams (N=240)

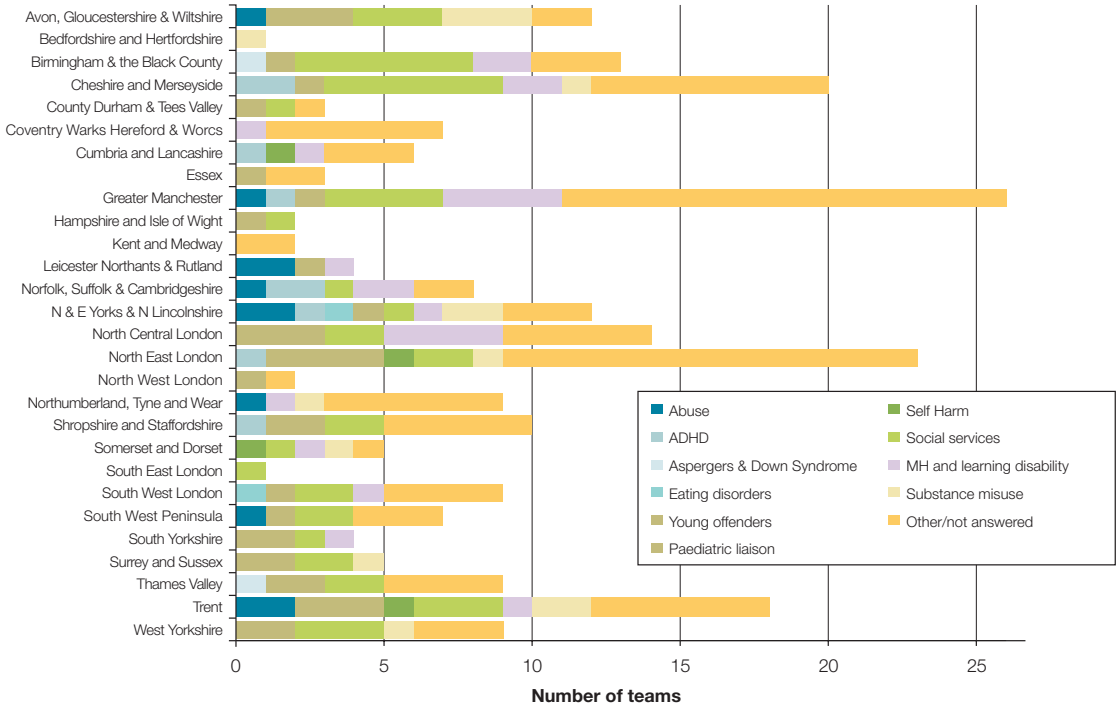
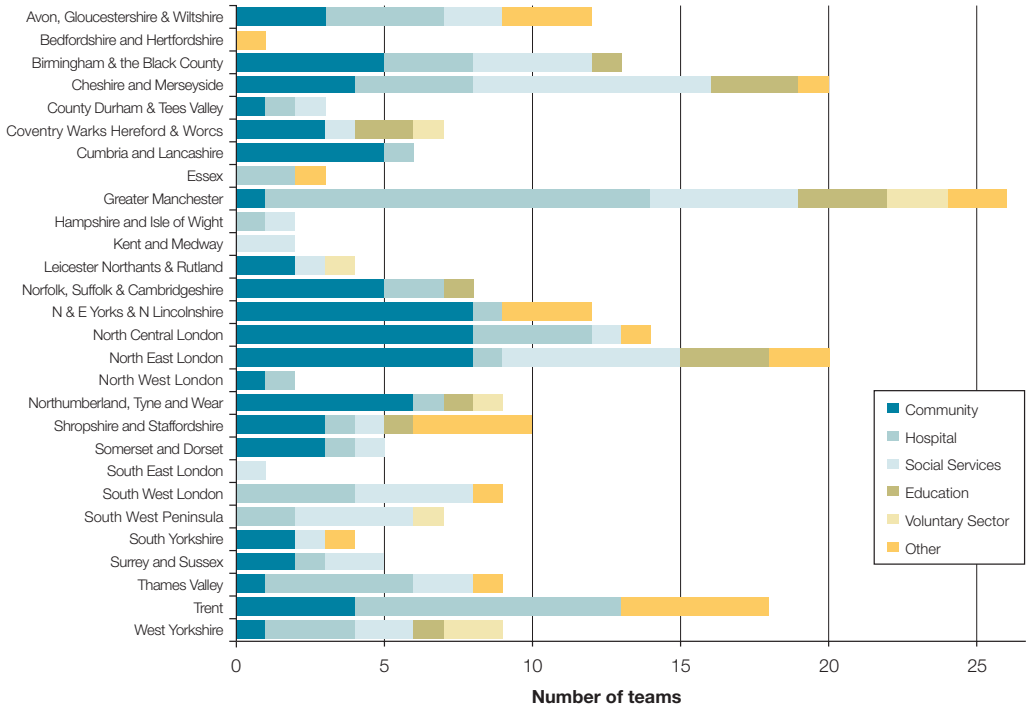


Fig. 2.3c: Location of targeted teams (N=240)



2.4 Dedicated worker teams

There were 140 dedicated worker teams in 2004, an increase of 12 from the previous year. The staffing showed the reverse trend, falling from 565 WTE in 2003 to 271 WTE in 2004. The principle reason for this was improved accuracy of the mapping.

Staffing levels were expected to be small in these teams as they consist of specialist CAMHS input into teams which have a wider focus in meeting the diverse needs of children, young people and their families. Dedicated worker teams are often solo CAMHS workers who work alongside non-mental health professionals to ensure the delivery of integrated care. This was not always understood in previous year's mapping but as the process is becoming more familiar, greater consistency in the way services are mapped is being achieved. As a result, non-CAMHS staff have been removed from the mapping giving dedicated worker teams an average staff size of 1.9 WTE.

The focus of dedicated worker teams shows an emphasis on youth offending teams (25% of teams) , social services (11%) and educational settings (14%) (Fig. 2.4a). However, a wide range of different types of setting were apparent with very varied provision around the country (Fig. 2.4b).

A very small proportion of the dedicated worker teams were hospital based (10%). 24% were based in community clinics, 20% in social services settings and 15% in educational establishments. A quarter of teams were recorded in 'other' settings.

Fig. 2.4a: Focus of dedicated working teams (N=143)

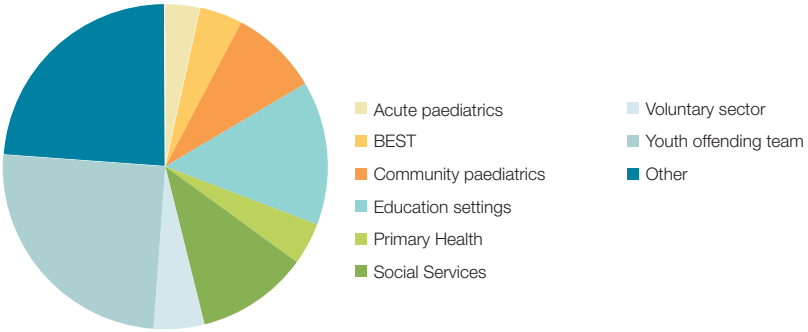


Fig. 2.4b: Focus of dedicated worker teams (N=143)

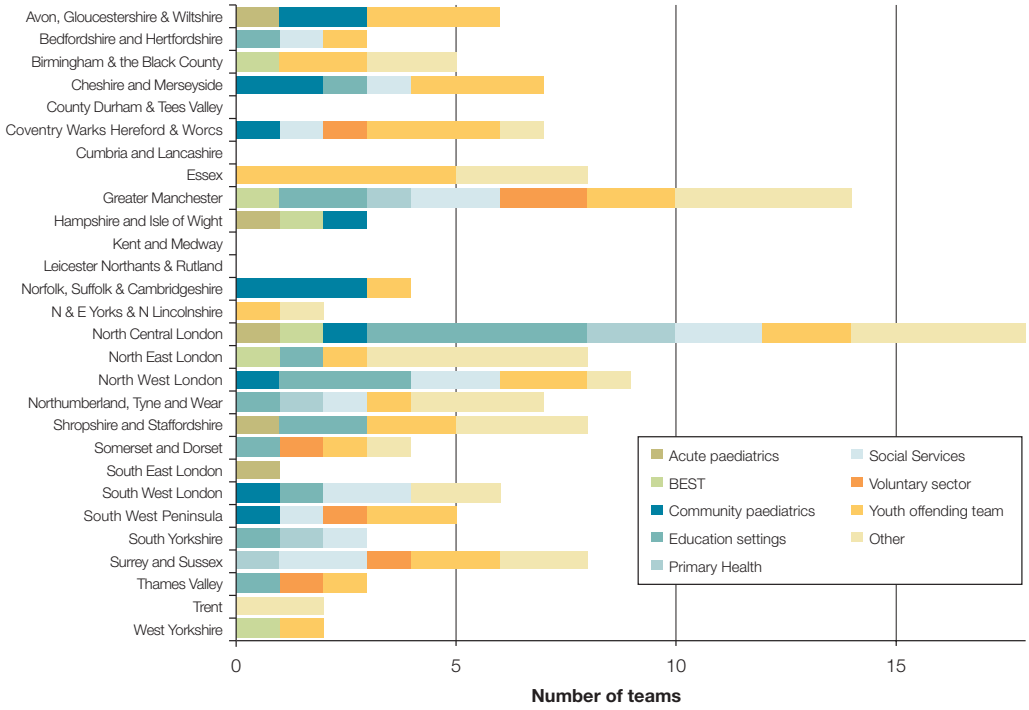
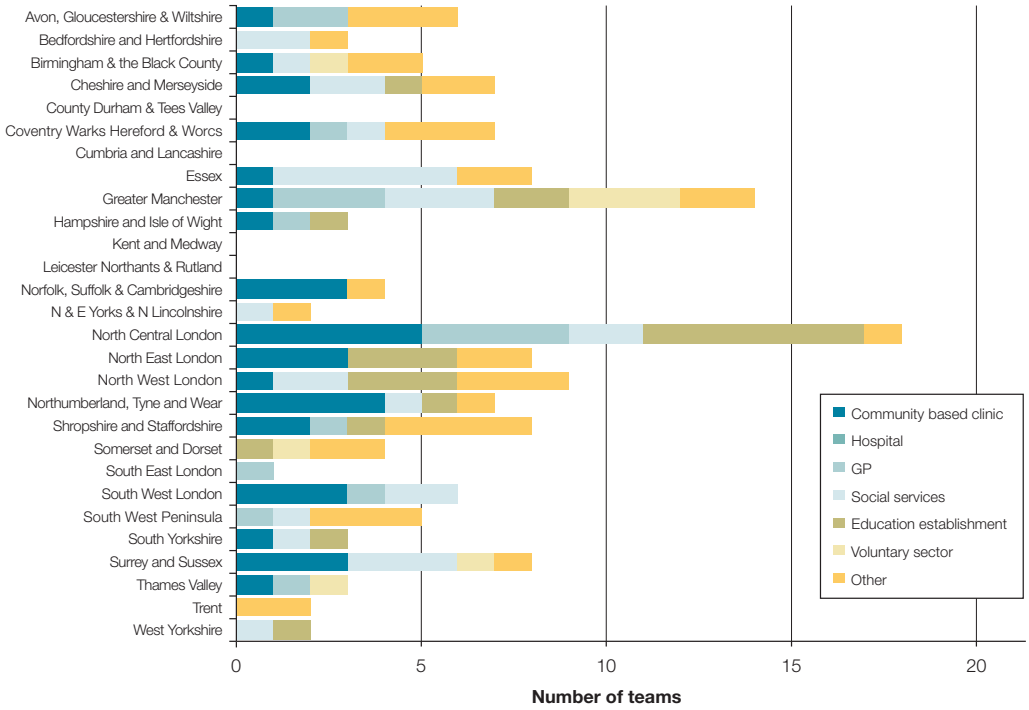


Fig. 2.4c: Location of dedicated worker teams (N=143)



2.5 Tier 4 services

Considerable change was found in the provision of Tier 4 services between 2003 and 2004. The number of teams/units dropped from 122 in 2003 to 114 in 2004 while staff levels rose from 2,082 WTE to 2,176 WTE. At the same time the capacity of different aspects of tier 4 provision showed fluctuations (Table 2.5a).

Table 2.5a: Trends in Tier 4 provision 2003 and 2004

	2003	2004
Number of units	122	114
Staffing WTE	2082	2176
Inpatient commissioned beds	651	665
Day places	577	457
Intensive home support places	788	734
Intensive foster care placements	15	51

The number of inpatient beds remained static but for the first time, services were asked to make a distinction between the number of inpatient beds commissioned and the number currently occupied.

This showed that 86% of commissioned beds were in use on census day, an appropriate proportion for an acute service needing to be able to accommodate urgent admissions at short notice (Table 2.5b).

Apparent changes in the number of day places and the capacity of intensive home support teams should be treated with caution. Feedback from the field suggested that services had difficulty with these terms and therefore with how to map their data consistently. Another difficulty reported was the mapping of units which had multiple functions – the ability of the website to do this was not universally understood.

Although these tier 4 units are an important component in a comprehensive CAMH service, they often provide a wider than local, or a national service. Therefore these teams cannot be matched to a specific population and comparisons between SHAs are invalid.

Table 2.5b: Tier 4 teams and inpatient bed capacity

SHA	No. Tier 4 Teams	No. Tier 4 Staff (WTE)	Inpatient Units	Inpatient beds currently in use	All commissioned beds
Avon, Gloucestershire & Wiltshire	4	76.51	2	17	22
Bedfordshire and Hertfordshire	1	26.9	1	12	14
Birmingham & the Black Country	7	201.54	5	44	64
Cheshire and Merseyside	5	88.68	2	21	24
County Durham & Tees Valley	2	57.25	2	22	12
Coventry Warks Hereford & Worcs	-	-	-	-	-
Cumbria and Lancashire	2	40.47	1	12	3
Essex	3	38.2	1	10	10
Greater Manchester	9	147.08	3	37	37
Hampshire and Isle of Wight	2	56.28	1	20	20
Kent and Medway	1	18.84	1	1	7
Leicester Northants & Rutland	3	72.81	2	15	15
Norfolk, Suffolk & Cambridgeshire	4	69.65	2	11	20
N & E Yorkshire & N Lincolnshire	4	67.57	3	22	14
North Central London	11	153.23	4	19	55
North East London	2	64.8	2	24	22
North West London	3	68.69	2	49	52
Northumberland, Tyne and Wear	6	255.31	6	66	65
Shropshire and Staffordshire	1	26.92	1	10	10
Somerset and Dorset	2	68.5	2	6	16
South East London	15	126.81	3	29	21
South West London	5	97.65	4	28	31
South West Peninsula	4	54.38	2	10	18
South Yorkshire	3	58.1	2	4	16
Surrey and Sussex	2	36.01	1	24	24
Thames Valley	4	79.77	3	17	34
Trent	4	60.69	2	24	24
West Yorkshire	5	63.26	3	15	15
Total	**114**	**2175.9**	**63**	**569**	**665**

2.6 On-call provision and emergency response

Children and young people presenting as emergencies or as requiring urgent assessment and intervention include: those who have rapidly developed a serious or life-threatening condition; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support.

(NSF for Children, Young People and Maternity Services 2004 –Standard 9, p.18.)

Improvements have continued to be made to the provision of on call and emergency services resulting in a slow but steady rise in the provision of on call services since 2003. There were 65 services with on call provision in 2002, 74 in 2003 and 78 in 2004. However, the proportion of services with on call provision remained static in the last 12 months at 56% of all services (the overall number of services has risen.)

The number of services offering a specialist CAMHS response stood at 62 at the end of the mapping exercise. This was 7 more services than the previous year but the proportion of services remained at 78%.

Overall, 60 services had no on call provision but 44 of these could provide an emergency appointment with specialist CAMHS staff the next working day (Table 2.6).

Only 19 services reported no on call or emergency response at all.

Table 2.6: On-call and emergency provision

SHA	Number or services	Has on-call	On call has CAMHS reponse	Next day appointent
Avon, Gloucestershire & Wiltshire	7	5	3	1
Bedfordshire and Hertfordshire	2	1	1	1
Birmingham & the Black Country	7	3	1	5
Cheshire and Merseyside	7	2	2	5
County Durham & Tees Valley	2	1	1	1
Coventry Warks Hereford & Worcs	5	3	3	11
Cumbria and Lancashire	9	-	-	3
Essex	2	-	1	1
Greater Manchester	9	5	5	2
Hampshire and Isle of Wight	8	7	5	1
Kent and Medway	2	1	1	1
Leicester Northants & Rutland	3	3	2	-
Norfolk, Suffolk & Cambridgeshire	8	2	2	6
N & E Yorkshire & N Lincolnshire	5	4	4	1
North Central London	10	9	8	-
North East London	2	2	2	-
North West London	4	4	1	-
Northumberland, Tyne and Wear	7	3	2	3
Shropshire and Staffordshire	3	1	1	1
Somerset and Dorset	3	2	1	2
South East London	3	1	1	1
South West London	1	1	-	-
South West Peninsula	4	2	1	2
South Yorkshire	5	2	1	1
Surrey and Sussex	5	3	3	1
Thames Valley	7	6	5	-
Trent	5	3	4	2
West Yorkshire	4	2	1	2
Total	**139**	**78/139**	**62/78**	**44/61**

2.7 Services for people of sixteen and seventeen years of age

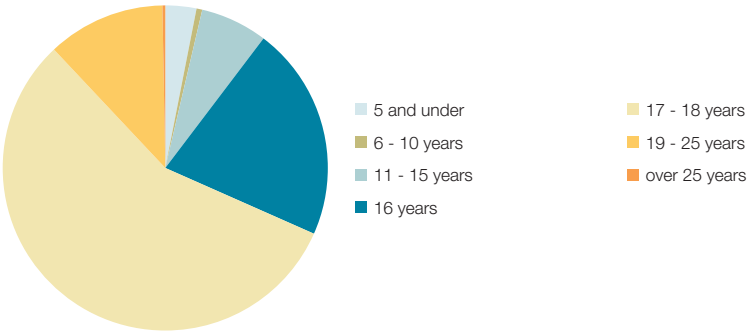
There is a broadly held view and concern that many young people of sixteen and seventeen years of age are not receiving the services they require since they fall into the gap between child and adult services, the latter tending to have a lower age threshold for their services of eighteen years… A degree of flexibility is clearly required to ensure that young people receive treatment in an environment that promotes their engagement and responds to their developmental needs.

(NSF for Children, Young People and Maternity Services 2004 –Standard 9, p.21)

As comprehensive CAMH services should cater adequately for the needs of older adolescents aged 16 and 17, the mapping collected information on the age range of the team provision described and the age of the children and young people using the services.

Out of the total 989 CAMHS teams, 101 (10%) had an upper age limit of 15 years or below and a further 211 teams (21%) worked with children up to the age of 16. Of the 677 (69%) of teams that has an upper age limit above 16 years old, 558 teams (57%) specifically included 16 and 17 year olds and 119 teams (12%) worked with young people up to the age of 25 (Fig. 2.7).

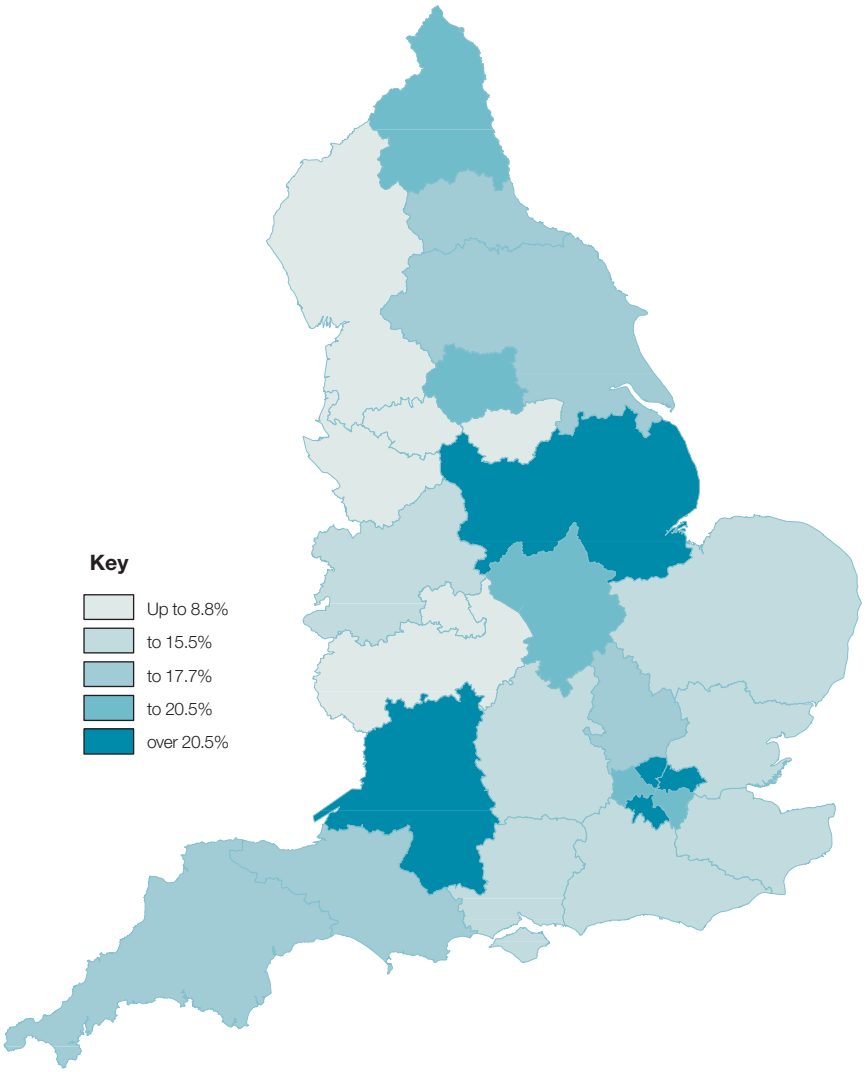
Fig. 2.7: Upper age limit of team provision (N=989)



In tier 2/3 teams, 10,873 cases, 12% of the caseload was aged 16 to 18. In tier 4 teams the proportion of older adolescents was greater at 25%. Nationally this was 1,165 cases. Overall, 12,038 cases were aged 16 to 18, 12% of the total caseload (see section 4.5 below).

Local variation in CAMHS provision for young people over the age of 16 can be seen in Map 2.7 with a range across SHA of 8.8% to 20.5% of caseload. As only 1% of cases were aged over 18, this pattern is essentially that of 16 and 17 year olds.

Map 2.7: Proportion of caseload age 16 or over



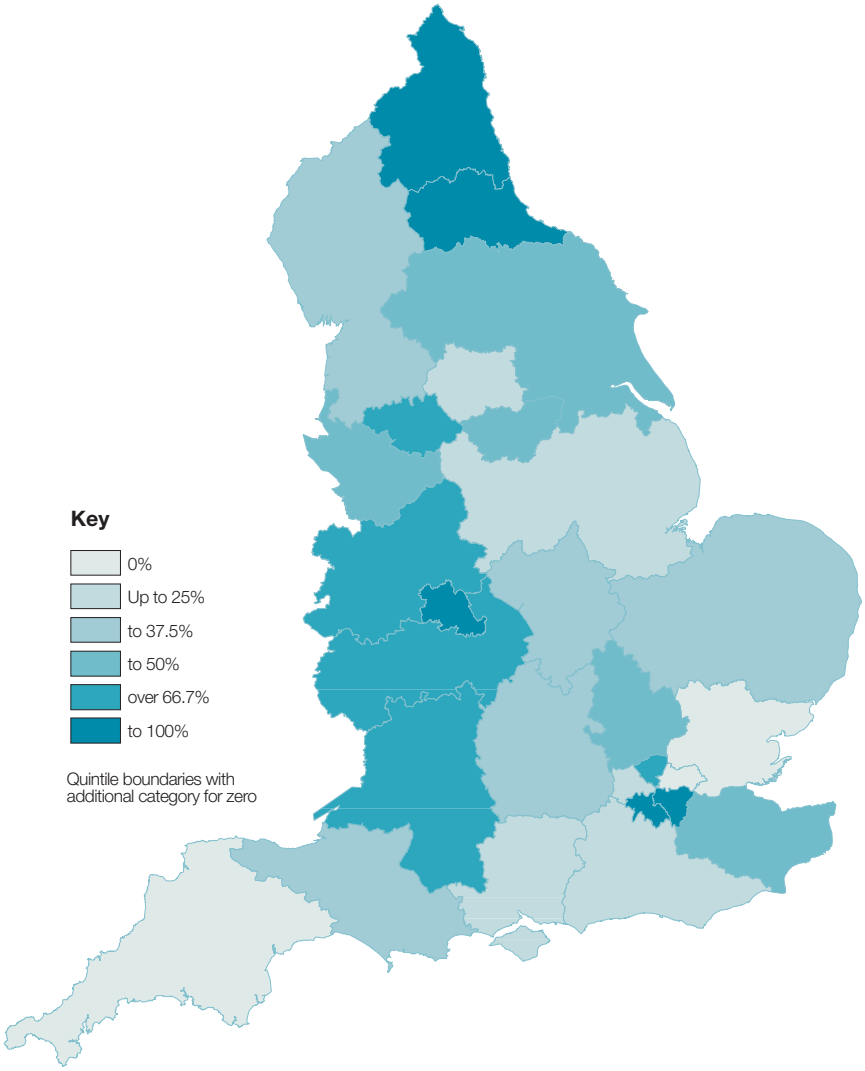
2.8 Learning disability and mental health specialisms

There is a need to ensure that children and young people with learning disability who require psychiatric care have access to appropriate services that meet their needs and that they are not disadvantaged because of their disability.

(NSF for Children, Young People and Maternity Services 2004 –Standard 9. p.23.)

A minority of services reported having specialist provision for children and young people with learning disabilities in need of psychiatric care, but the number had increased considerably since 2003. In total, 62 services (45%) indicated having a learning disability service compared to 44 in 2003 and 42 in 2002. In 2004, three SHAs were without specialist learning disability CAMHS provision (Map 2.8).

Map 2.8: Proportion of services with specific LD provision



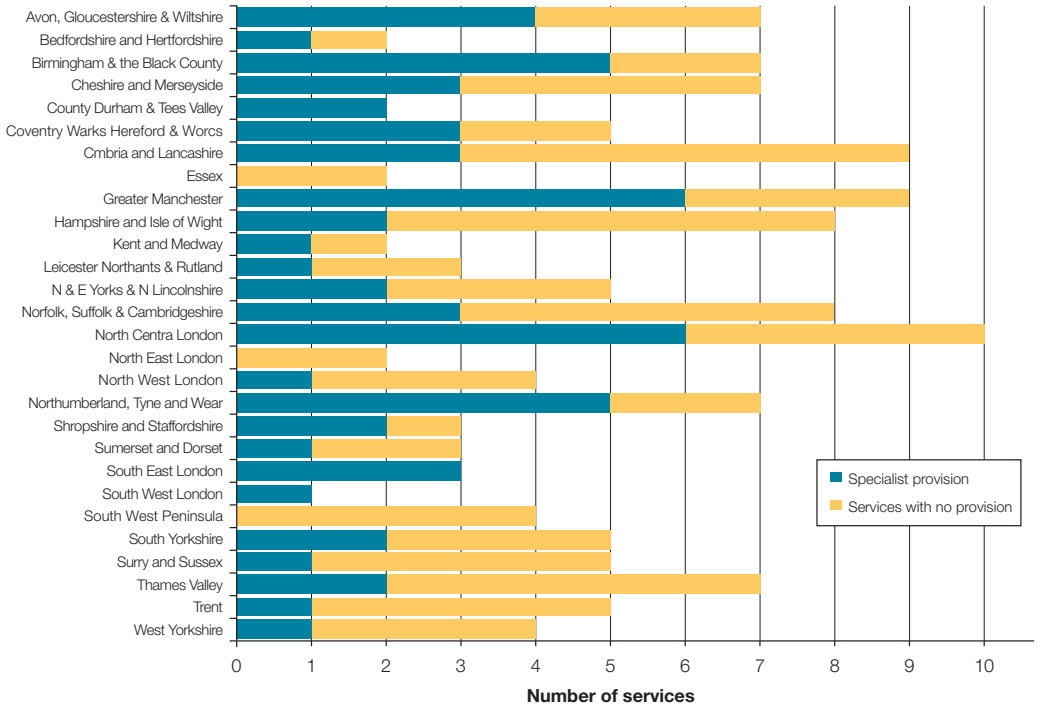
From an examination of tier 2/3 and tier 4 teams it was only possible to identify some specialist learning disability teams. 23 of the targeted teams recorded having a focus on supporting children with mild to moderate learning disabilities. These teams reported 918 cases with the 'special characteristic' of learning disability but a total caseload of 1,204, suggesting that some of the teams may have had multiple functions. Similarly, many of the 8,764 children and young people with learning disabilities included in the mapping were supported by non-specialist learning disability teams.

An examination of the teams that supported children with learning disabilities revealed:

- 5276 cases in generic multi-disciplinary teams (60% of learning disability cases)
- 849 cases in single professional generic teams (10% of learning disability cases)
- 1770 cases in targeted teams (20% of learning disability cases)
- 403 cases in dedicated worker teams (5% of learning disability cases)
- 466 cases in tier 4 teams (5% of learning disability cases).

Distribution of this care was very uneven across the country (Fig. 2.8).

Fig. 2.8: Learning disability and mental health provision



2.9 CAMHS support for looked after children

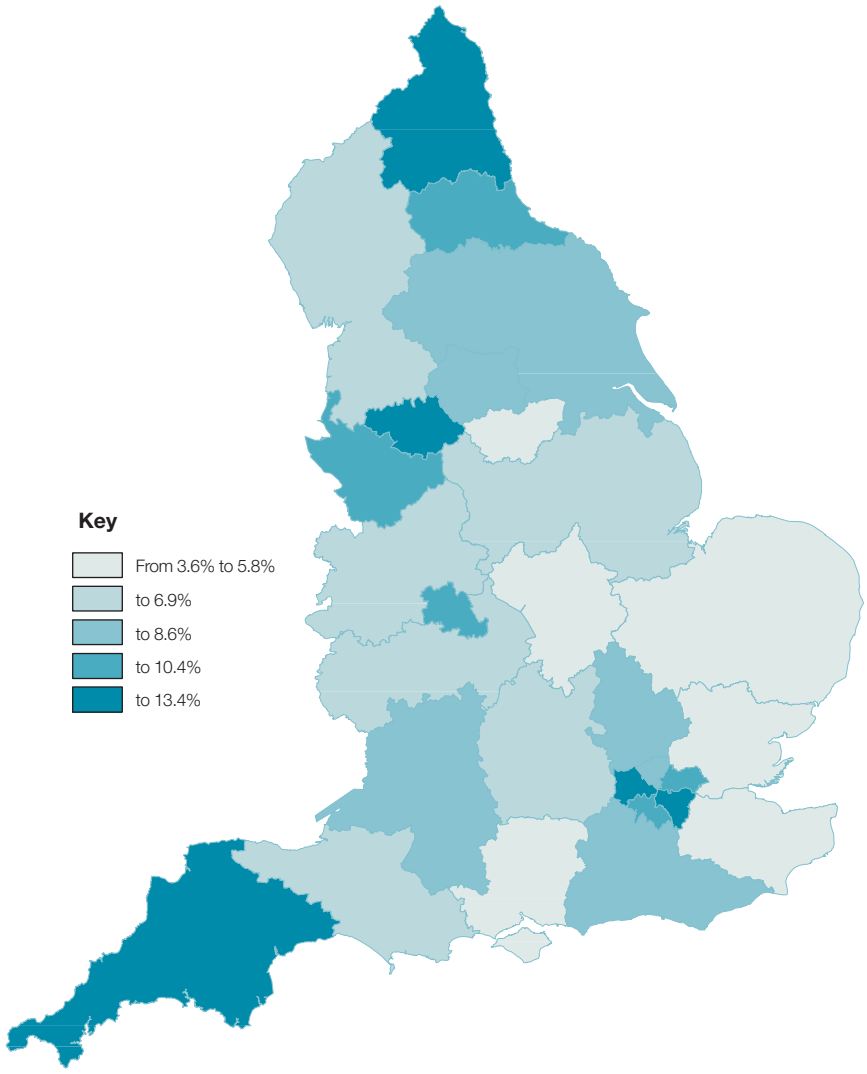
Looked after children are five times more likely than their peers to have a mental health disorder.

(NSF for Children, Young People and Maternity Services 2004 –Standard 9. p.7.)

There were 8,448 cases identified as looked after children in the mapping, 8% of the total caseload. Provision for this group varied around the country with the proportion of caseload varying from 3.5% to 13.4% (see Map 2.9).

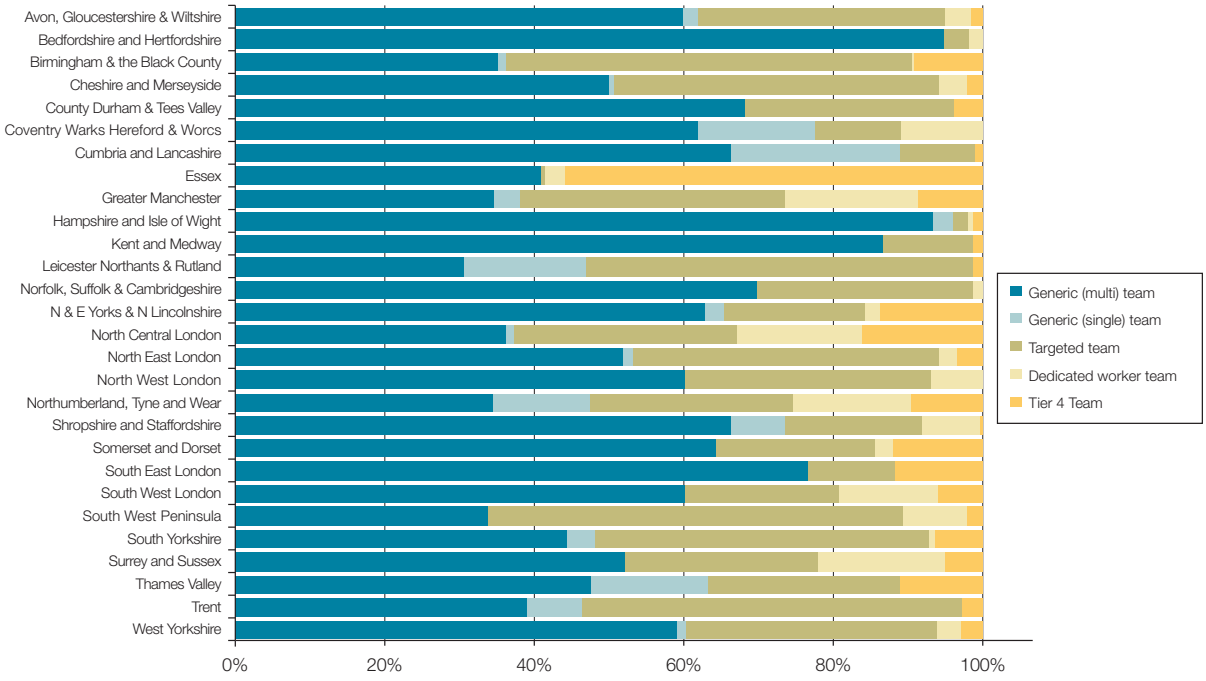
Overall, 62 teams had a social services focus but this did not mean that they were exclusively concerned with the support of looked after children. 46 of these were targeted teams and 16 were dedicated worker teams. Looked after children made up 70% of the caseload of the social services targeted teams and 45% of caseload of the dedicated worker teams.

Map 2.9: Looked after children as proportion of caseload (2004)



Overall, 55% of looked after children (4,655) received care from multiprofessional generic teams, 29% (2,438) from targeted teams, 7% (574) from tier 4 teams, 5% (458) from dedicated worker teams and 4% (323) from generic single discipline teams. The emphasis on support by generic teams supporting looked after children in some localities can be seen in Fig. 2.9.

Fig. 2.9: Looked after children by team type (N=8,448)



2.10 Services for young offenders

There were 20 teams that targeted the needs of young offenders and 36 dedicated workers who provided specialist CAMHS input within youth offending teams (Fig. 2.10a). Young offenders made up 5% of the total caseload (5,173 cases). Over half of them were supported by generic teams, 20% by targeted teams, 8% by dedicated worker teams and six percent by tier 4 units (Fig. 2.10b). It should be noted that the mapping did not cover secure provision from the independent sector.

Fig. 2.10a: Young offenders team provision (N=56)*

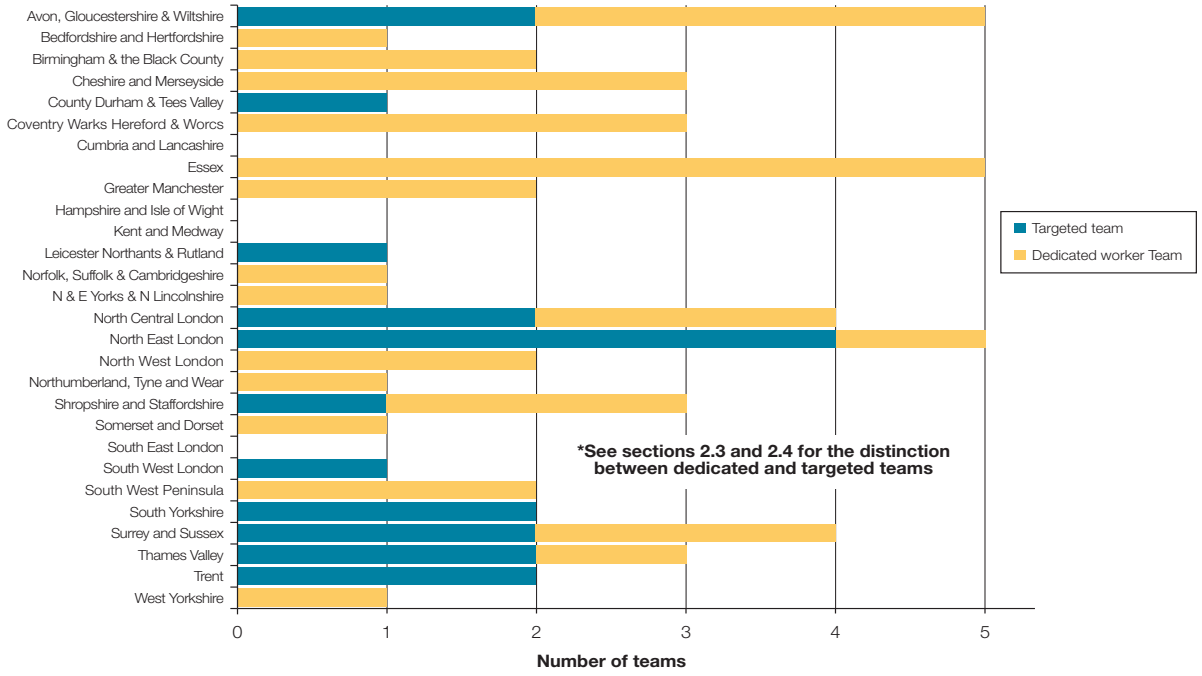
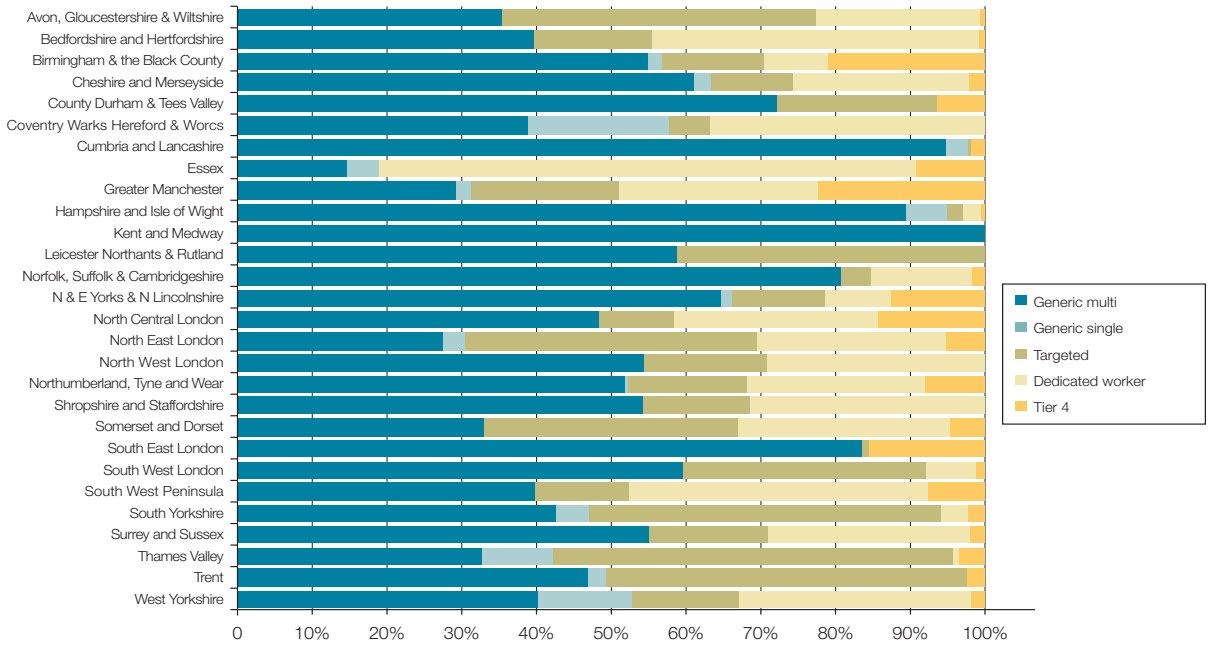


Fig. 2.10b: Young offender cases by team type (N=5,173)



2.11 Staff use of information technology

Effective implementation of the CNSF depends on staff being facilitated to integrate interagency and interprofessional working, case management, working from an evidence base and auditing and monitoring service outcomes. An essential tool in this is Information Technology. In the mapping a series of questions were asked about staff access to and use of internet systems. In 2004 it was found that use of web-based systems had increased from the previous year but it was far from universal. It was found that of staff:

- 96% had access to email and it was used by 63% (Fig. 2.11a)
- 96% had access to the Internet and it was used by 61% (Fig. 2.11b)
- 90% had access to the NHS net and it was used by 51% (Fig. 2.11c)
- 29% had access electronic clinical notes and 14% use them (Fig. 2.11d)
- 67% had access to clinical information on the Internet such as Cochran Reviews and 31% use it (Fig. 2.11e)
- 70% had access to activity data on the web and 35% used it (Fig. 2.11f).

Fig. 2.11a: Staff access to and use of email

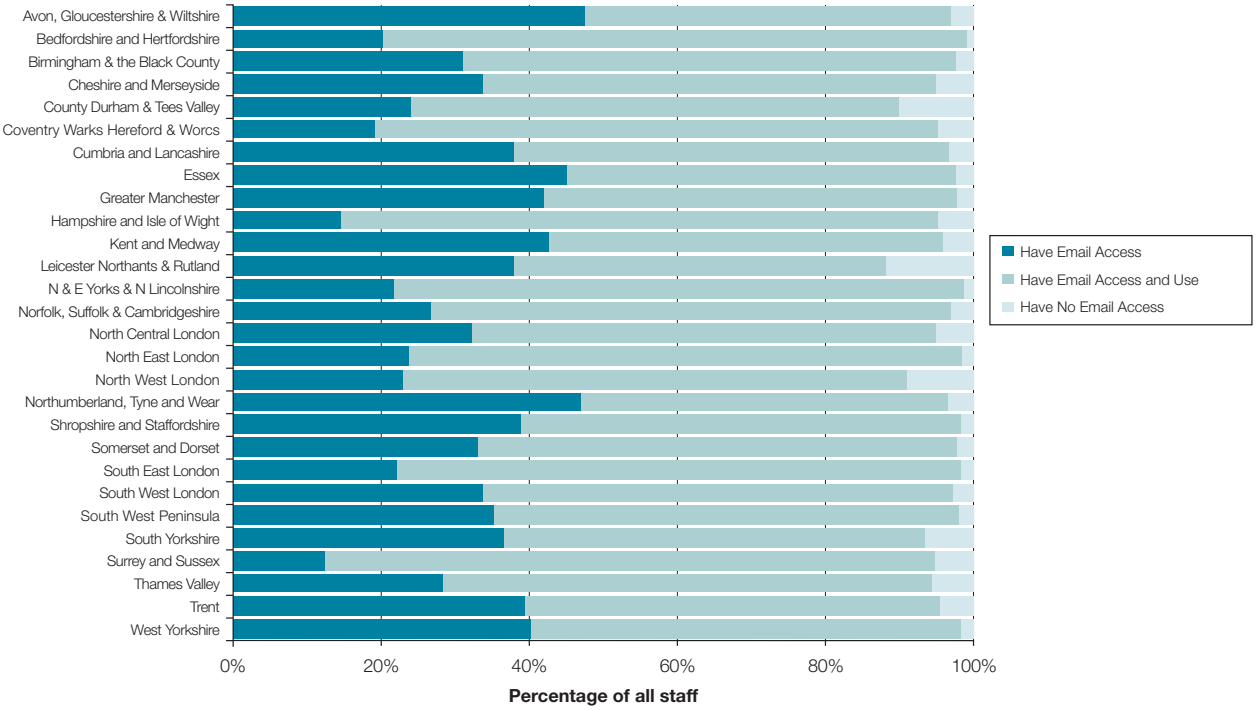


Fig. 2.11b: Staff access to and use of internet

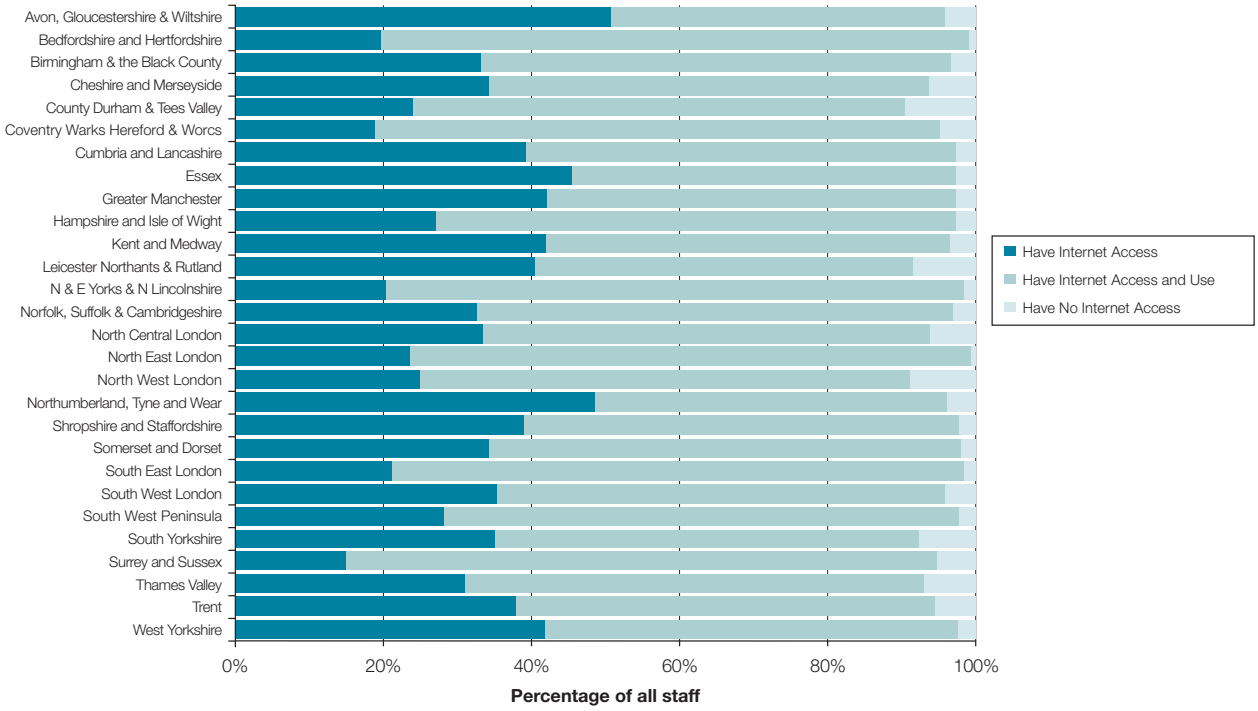


Fig. 2.11c: Staff access to and use of NHS Net

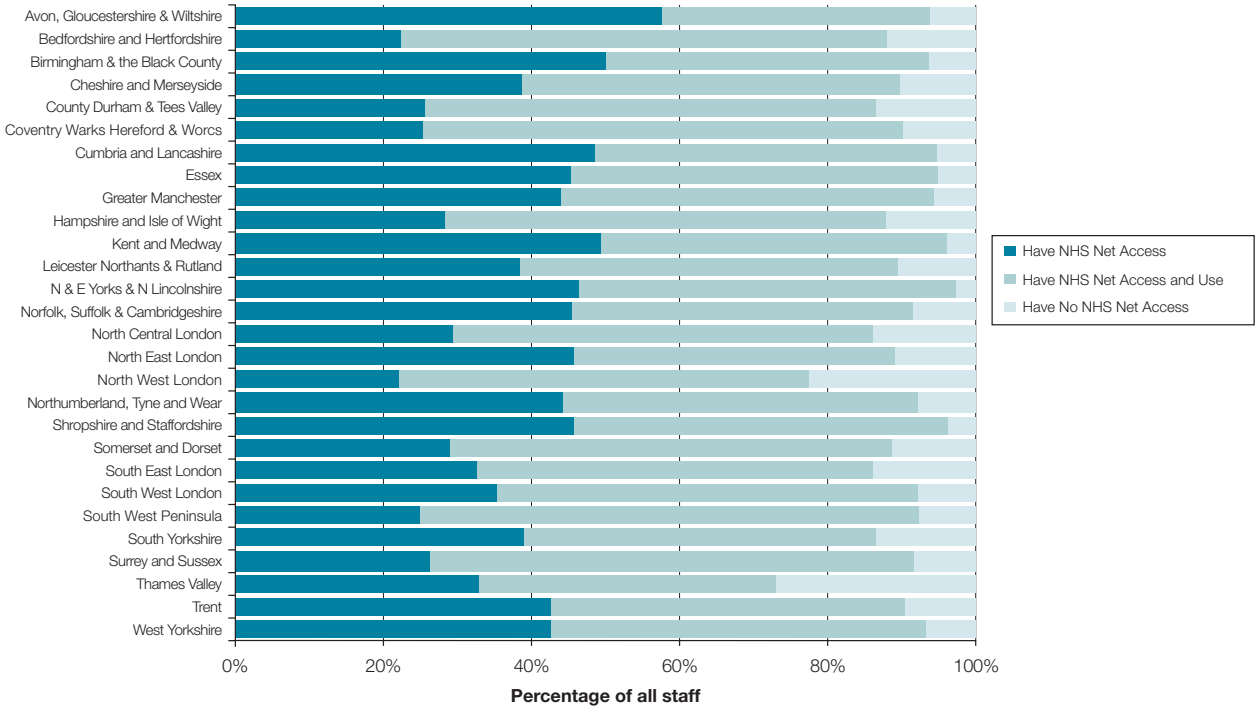


Fig. 2.11d: Staff access to and use of electronic clinical notes

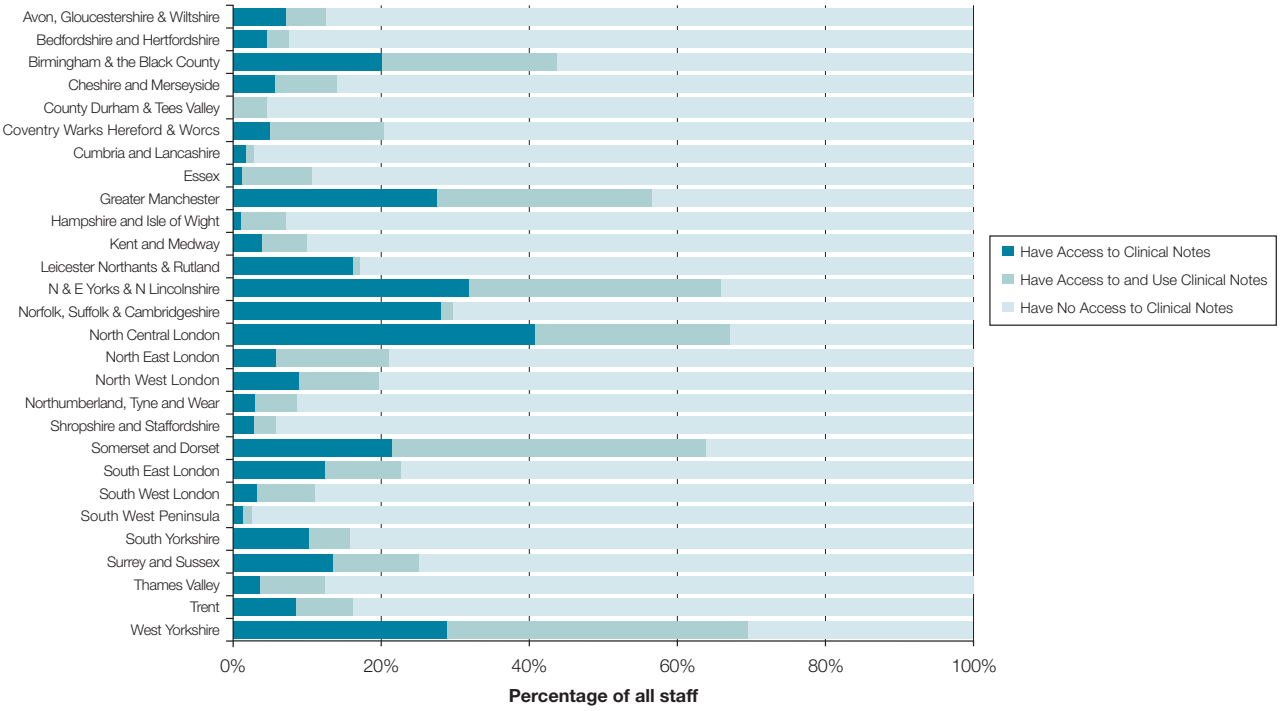


Fig. 2.11e: Staff access to and use of electronic clinical information

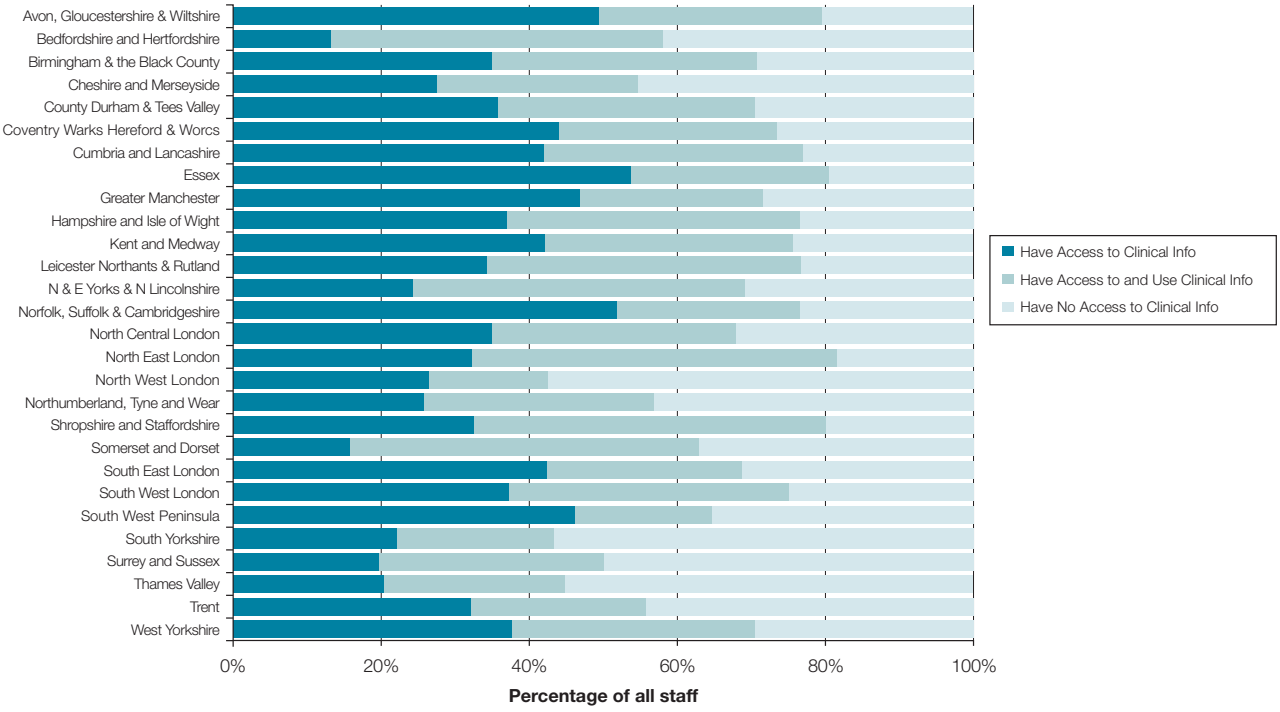
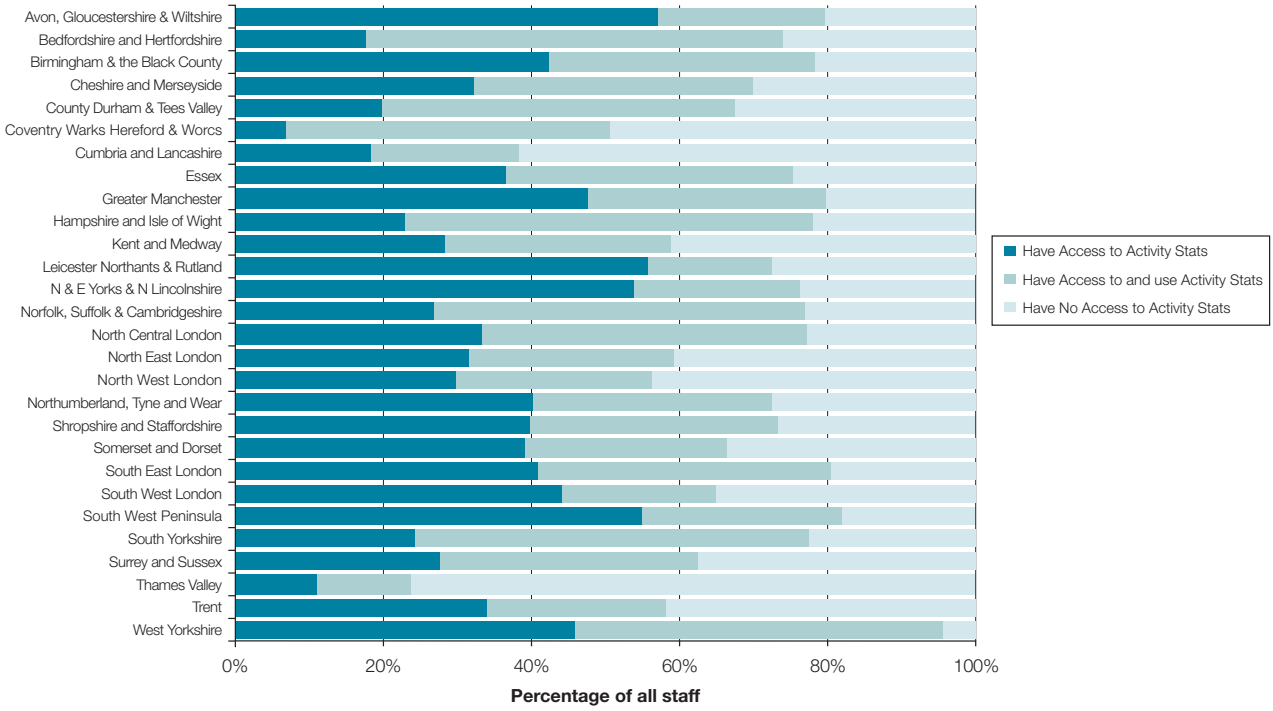


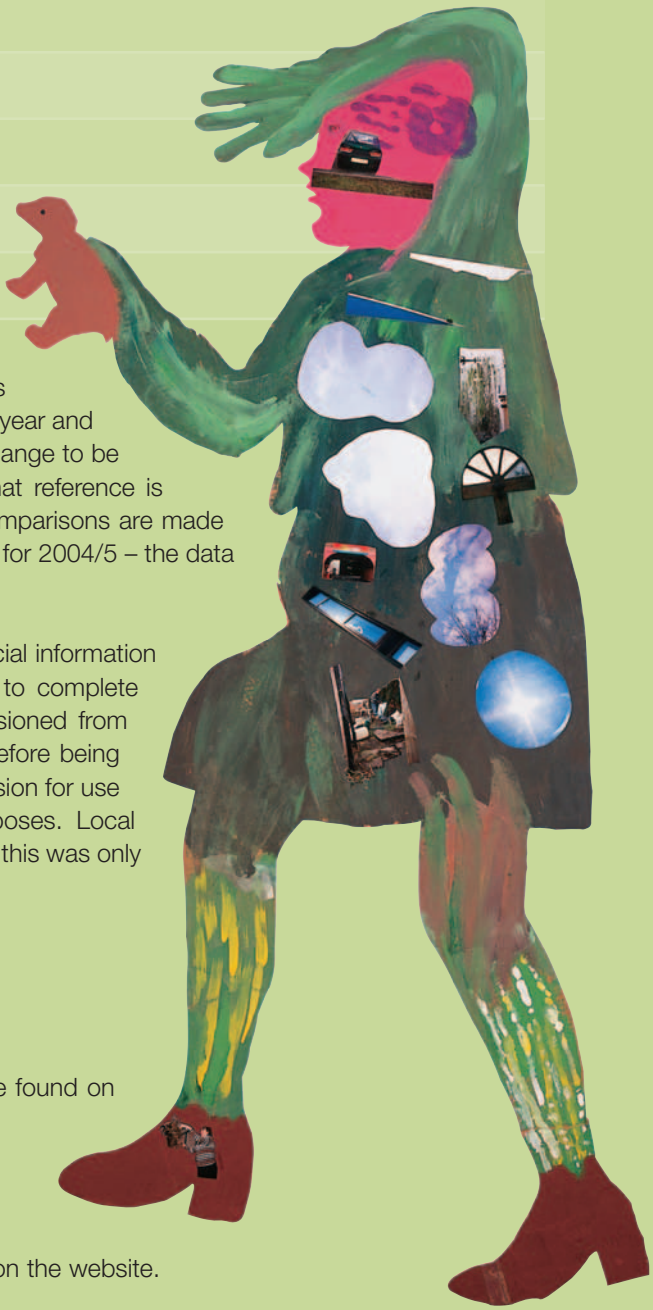
Fig. 2.11f: Staff access to and use of activity statistics



Chapter 3:

Investment

This chapter summarises information on investment in specialist CAMH services. It includes sections on:



In each annual CAMHS mapping exercise, information is requested on the actual CAMHS budget of the previous financial year and the predicted budget of the current year. This enables budget change to be calculated from the data supplied in a single year, ensuring that reference is being made to the same services. Therefore, in this section, comparisons are made between the actual budget for 2003/4 and the predicted budget for 2004/5 – the data was provided in early 2005 before the end of the financial year.

It is important to note that changes were made in the way financial information was mapped in 2004. For the first time, PCTs were required to complete commissioning questionnaires stating how much was commissioned from whom. This data was signed off by the PCT Chief Executive before being handed on to the Department of Health and Healthcare Commission for use in the measurement of performance and for star rating purposes. Local authorities were also asked to complete commissioning data but this was only on a voluntary basis.

Detailed tables of the data used in the following chapter can be found on the CAMHS mapping website at:

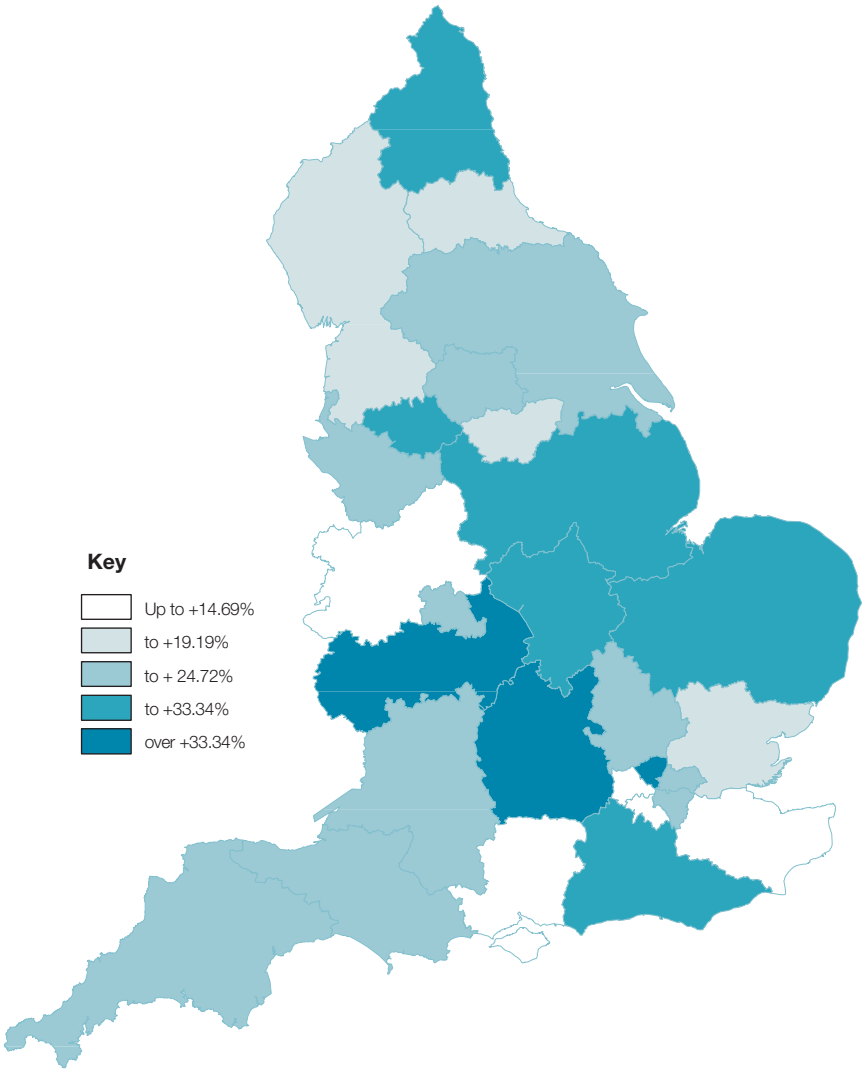
www.camhsmapping.org.uk/2004

All figures and maps correspond to tables of the same number on the website.

3.1 Total budget and budget change 2003/4 and 2004/5

Total investment in CAMHS tiers 2-4 was £339,797k in 2003/4 and the predicted budget for 2004/5 was £416,304k. This represents an increase of £76,507k (23%). Across the country, the change within SHAs ranged from 11% to 45% (Map 3.1, Table 3.1).

Map 3.1: Budget change 2003/4 - 2004/5



It is worth noting that the budget predicted for 2003/4 in the previous mapping exercise was £335,468k, only £4,329k less than actual budget, accuracy to within 1.3%. However, changes were found in the way the budget has been allocated between commissioners in the mapping in the last two years. In 2003, it was reported that PCTs were responsible for commissioning 71.8% of the 2002/3 budget and this share was predicted to drop to 69.6% in 2003/4. In fact, in 2003/4 the PCT share was reported to have risen to 82% of the annual budget, leaving local authorities with just 18% and other commissioners 0.03% (Table 3.1).

There are a number of explanations for this change. The data was provided by PCTs themselves in 2004 and therefore the accuracy of the information could have improved. Also, local authorities were requested to complete

commissioning questionnaires in 2004 but their participation was voluntary whereas PCTs were required to do so for star rating purposes. Therefore more complete returns were received from PCTs and LA data is likely to be under-reported (Table 3.1). Finally, while local authorities will have received their CAMHS Grant in 2003/4, it is often passed directly to the PCT for investment in health CAMHS provision. In these cases it may have been reported by the PCT and not by the LA.

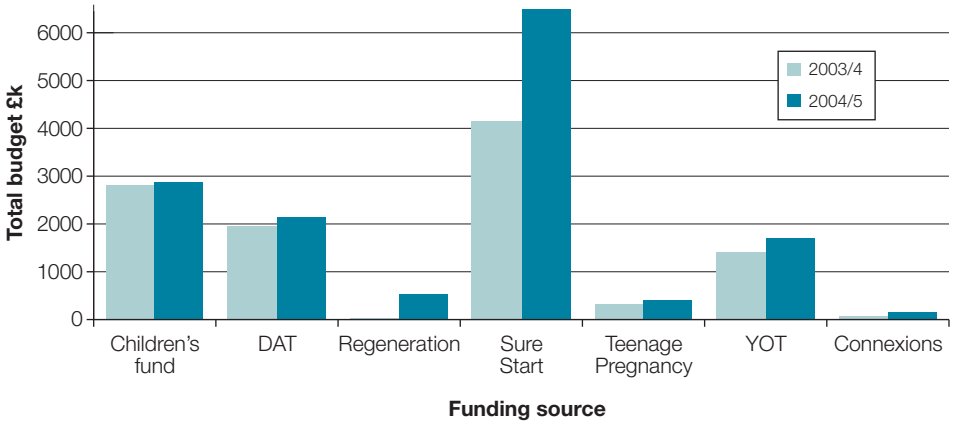
Table 3.1: Budget by commissioner

SHA	Total budget 2003/4 £k	Total Budget 2004/5 £k	% Budget Change	PCT budget as % of whole	LA Budget as % of whole	Other Budget as % of whole
Avon, Gloucestershire & Wiltshire	13,244	16,517	25%	94%	6%	
Bedfordshire and Hertfordshire	10,364	12,761	23%	83%	17%	
Birmingham & the Black Country	13,889	16,776	21%	79%	21%	
Cheshire and Merseyside	11,965	14,891	24%	84%	16%	
County Durham & Tees Valley	9,809	11,612	18%	93%	7%	
Coventry Warks Hereford & Worcs	4,805	6,860	43%	94%	6%	
Cumbria and Lancashire	10,349	12,335	19%	89%	11%	
Essex	10,939	12,783	17%	82%	18%	
Greater Manchester	14,072	18,130	29%	88%	11%	0.4%
Hampshire and Isle of Wight	12,609	14,462	15%	89%	11%	
Kent and Medway	11,060	12,088	9%	100%	0%	
Leicester Northants & Rutland	9,043	12,059	33%	88%	12%	
Norfolk, Suffolk & Cambridgeshire	7,896	9,690	23%	93%	7%	
N & E Yorkshire & N Lincolnshire	16,389	20,771	27%	99%	1%	
North Central London	13,670	19,791	45%	81%	19%	
North East London	15,879	19,221	21%	77%	23%	
North West London	37,261	41,224	11%	43%	57%	0.1%
Northumberland, Tyne and Wear	15,543	19,724	27%	95%	5%	
Shropshire and Staffordshire	7,431	8,514	15%	94%	6%	
Somerset and Dorset	5,280	6,461	22%	88%	12%	
South East London	11,769	14,238	21%	100%	0%	
South West London	11,342	12,743	12%	76%	24%	
South West Peninsula	6,244	7,673	23%	100%	0%	
South Yorkshire	9,069	10,695	18%	88%	12%	
Surrey and Sussex	15,856	20,546	30%	61%	39%	
Thames Valley	9,300	12,870	38%	82%	18%	
Trent	12,855	16,365	27%	86%	14%	
West Yorkshire	11,868	14,496	22%	80%	20%	
Total	**339,797**	**416,304**	**23%**	**82%**	**18%**	**0.03%**

3.2 Source of funding

Mainstream funding accounted for 95% of the total CAMHS budget in 2003/4. This amounted to £322,775k in 2003/4, whilst in 2004/5 it was predicted to be £416,304k. Of the remainder, the key sources were Sure Start/Children's Centres, the Children's Fund, Drugs and Alcohol and Youth Offending funding. The predicted increase in Sure Start/Children's Centre funding reflected the new investment in this area of work. The lack of growth in the Children's Fund is likely to be due to this funding initiative coming to an end. All other sources of income were expected to increase slightly (Fig. 3.2).

Fig. 3.2: Trends in investment in CAMH services from Government initiatives



3.3 Spend per child

The average cost per child overall was £30.7 in 2003/4 but throughout SHAs a large range was found, from £100.7 to £13.3 (Map 3.3a and Fig. 3.3a). However this range was largely due to the very high cost of tier 4 provision concentrated in a few localities. When the cost per child is examined in terms of provision for the local population only it is only £25.4 nationally, ranging from £49.3 to £15.9.

Map 3.3: Spend per child 2003/4

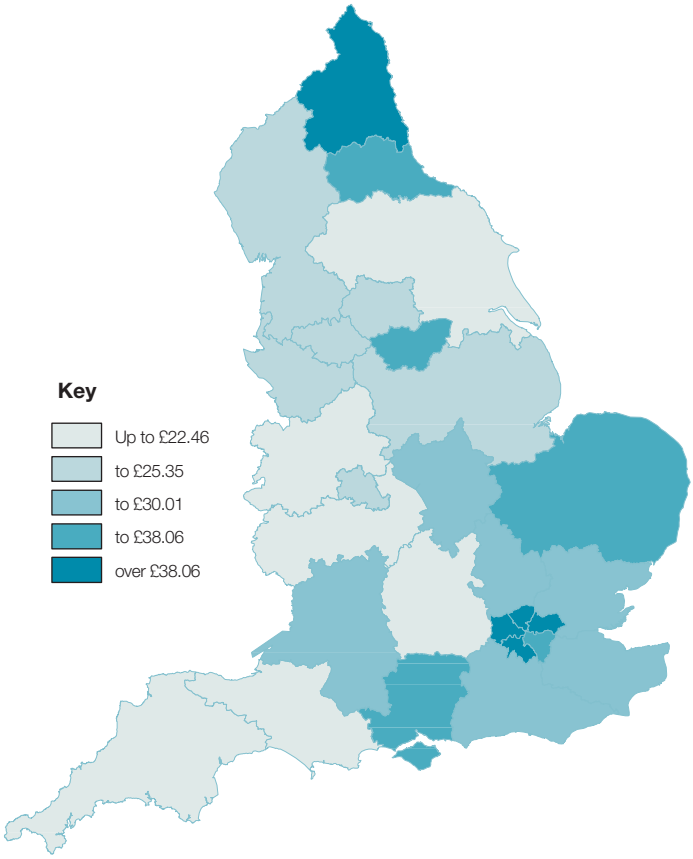
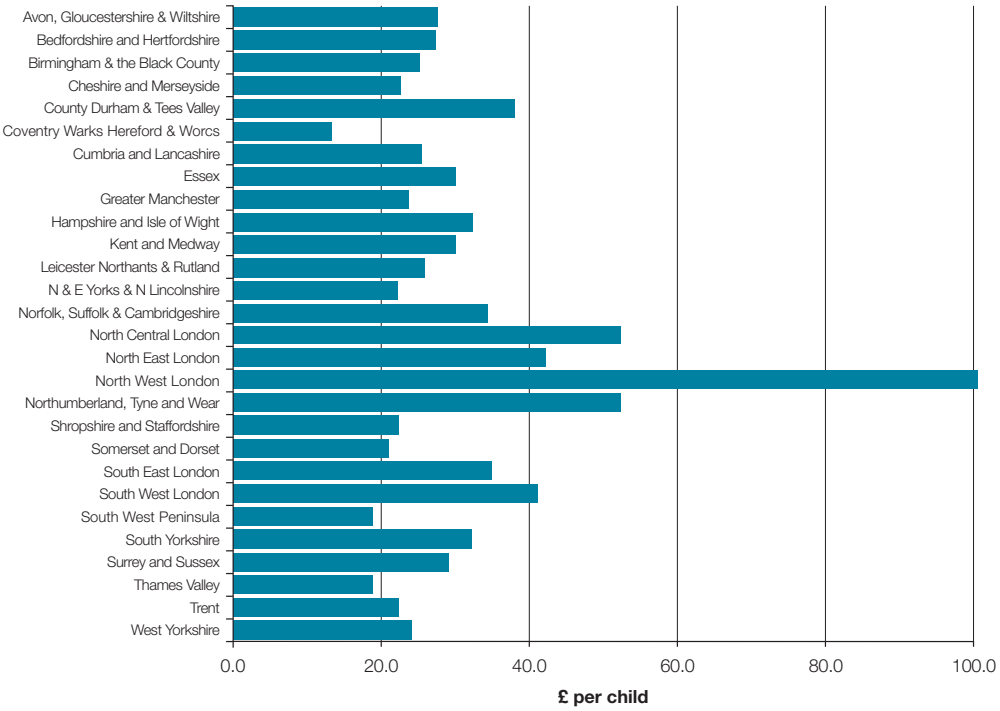


Fig. 3.3: Spend per child 2003/4



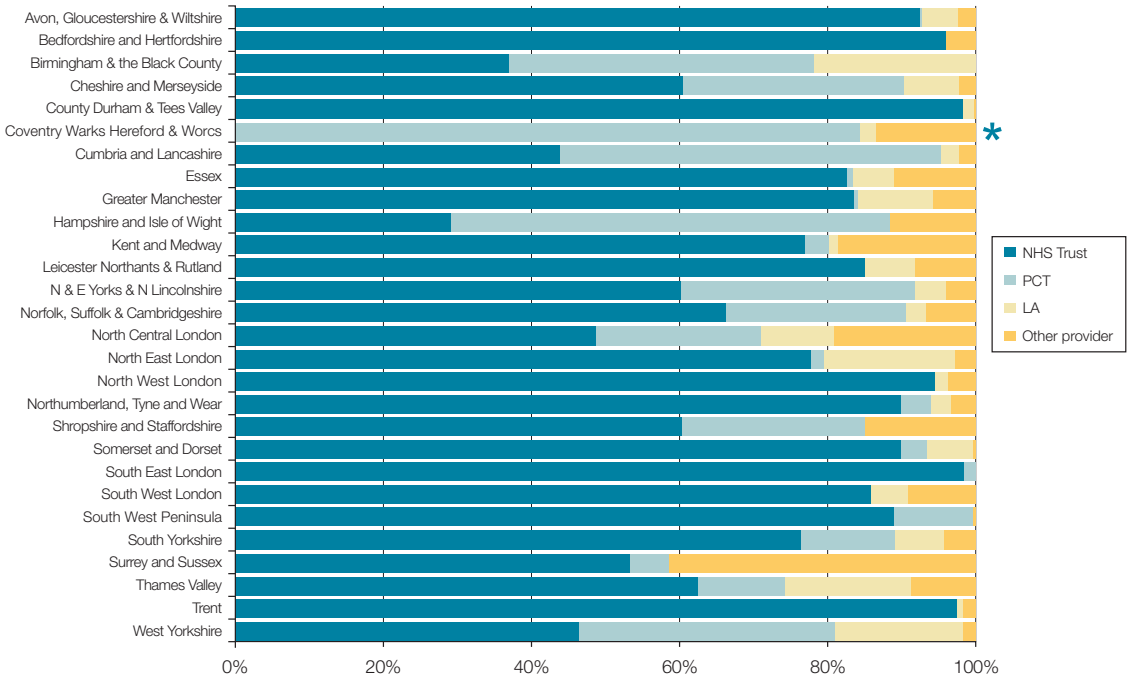
3.4 Provider share of budget

The mapping of who is commissioned to provide specialist CAMHS confirmed the predominance of NHS Trust provision. Overall NHS Trusts received 75% of the commissioning budget, PCTs received 14%, local authorities 6%, and 7% went to 'other' providers (Fig. 3.4). 'Other' providers included independent sector tier 4 provision and voluntary agencies.

There may have been an underreporting of LA involvement as it was not compulsory for LAs to complete commissioning data in 2004.

'NHS trusts' in this analysis include any type of NHS acute, community or specialist mental health provider trust. The last category was the most numerous.

Fig. 3.4: Provider share of budget

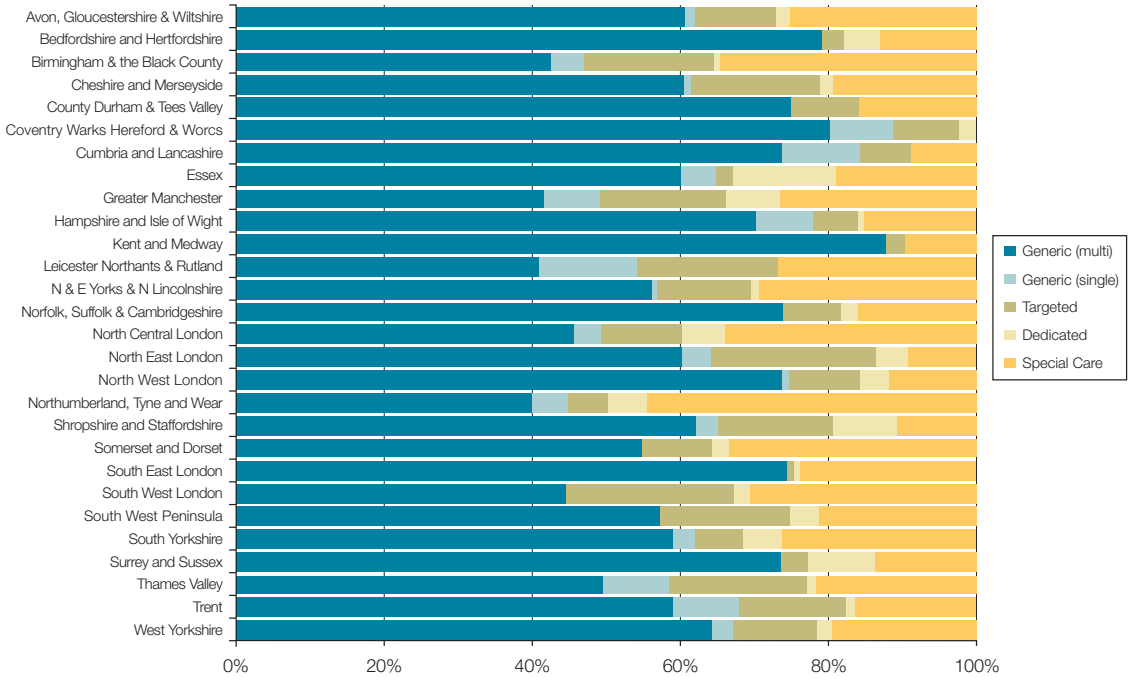


* Note: In this SHA, NHS mental health services are provided by PCTs. There are no specialist mental health trusts.

3.5 Team costs

As in previous years, the cost of each team was requested. These included team salaries and direct costs such as travel and office expenses, but excluded wider service overheads. In total the reported team costs in 2004 were £362,617k. In 2003 the equivalent costs were £294,921k, an increase of 23%. Local teams accounted for 77% compared to 80% in 2003. The average cost per team was £367,000 per team compared to £326,000 in 2003.

Fig. 3.5: Team costs by team type 2004/5



Chapter 4:
Activity

This chapter summarises the activity of the CAMHS workforce, derived from the caseload returns for the month of November 2004. It includes sections on:

A: Summary data:
- 4.1 National maps of Total Caseload per 100k population

B: Waiting times understood in terms of:
- 4.2 New cases seen
- 4.3 Cases waiting and length of wait
- 4.4 Length of treatment

C: Case characteristics such as:
- 4.5 Age and gender
- 4.6 Ethnicity
- 4.7 Primary Presenting Disorder
- 4.8 Referral source

Detailed tables of the data used in the following chapter can be found on the CAMHS mapping website at:

www.camhsmapping.org.uk/2004

All figures and maps correspond to tables of the same number on the website.

4.1 Summary of activity

Definitions for activity

Cases: A 'case' is a child, or a young person, or a child / young person and their family, for which a referral has been received and with whom CAMHS staff have actively been working. Where separate referrals were received for one or more siblings in a family, each sibling was counted as a separate case.

Active work: Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion. The frequency with which cases were seen during the study period was not collected during the 2004 mapping exercise.

Data collection period:
Tier 2/3 teams: caseload data were collected from the 1st to 30th November 2004.
Tier 4 teams: caseload data were collected for the six-month period June 1st to November 30th 2004.

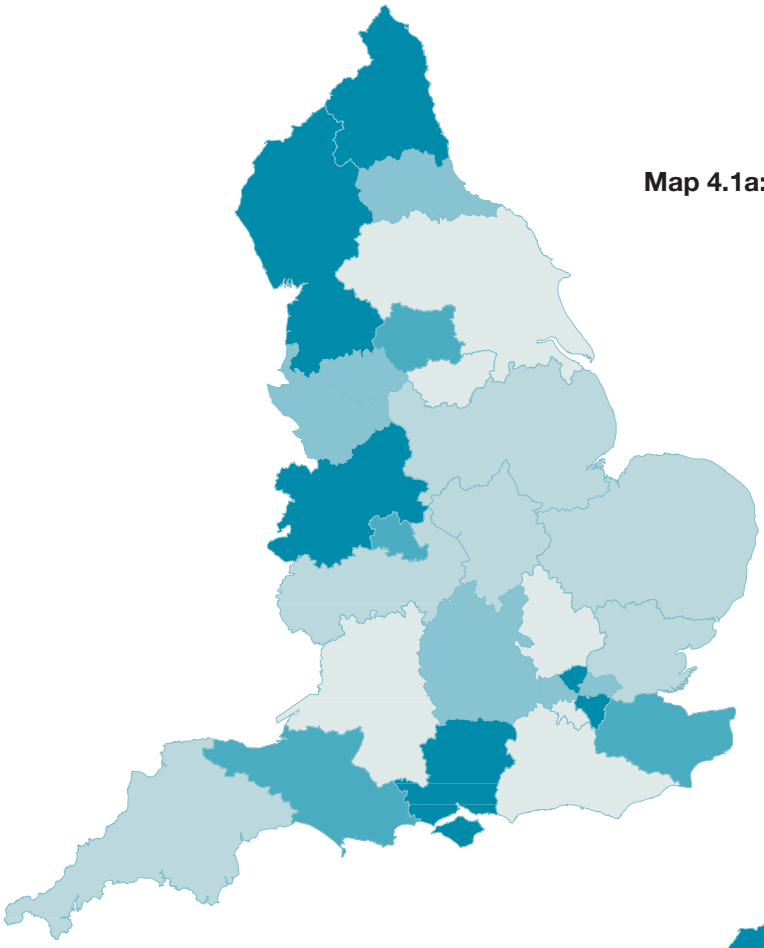
Caseload: The caseload is a count of the total number of cases a team worked with in the data collection period. This is collected at the team level only. If a number of staff within a team work with the same case it should be counted once. The team caseload is effectively a head count of those active cases that have been worked with in the sample period.

Note: a number of services reported having teams with no caseload during the data collection period due to the newness of the team (staff were in post but the team was not yet operational), posts being vacant, staff being on long-term sick/maternity leave or the activities of the team excluded casework.

In the mapping, activity is measured by the size and characteristics of the caseload. The caseload is the number of active cases worked with during the sample study periods. For tier 2/3 teams, this was the 4 weeks of November 2004 while for tier 4 teams, caseload was measured over the 6 months from June to November 2004 inclusive. The caseload is simply a headcount of children and young people who have received support, treatment and care from specialist CAMHS professionals. It does not reflect either the number of staff who have been involved in an intervention, or the intensity of the care provided.

A total of 104,744 cases were reported in 2004, an increase of 21.4% on the 86,521 cases reported in 2003. Examined against the population of 0-17 year olds in SHAs, the rate per 100k population receiving care was 958. This varied substantially between SHAs ranging from under 700 to over 1,700 (Map 4.1a).

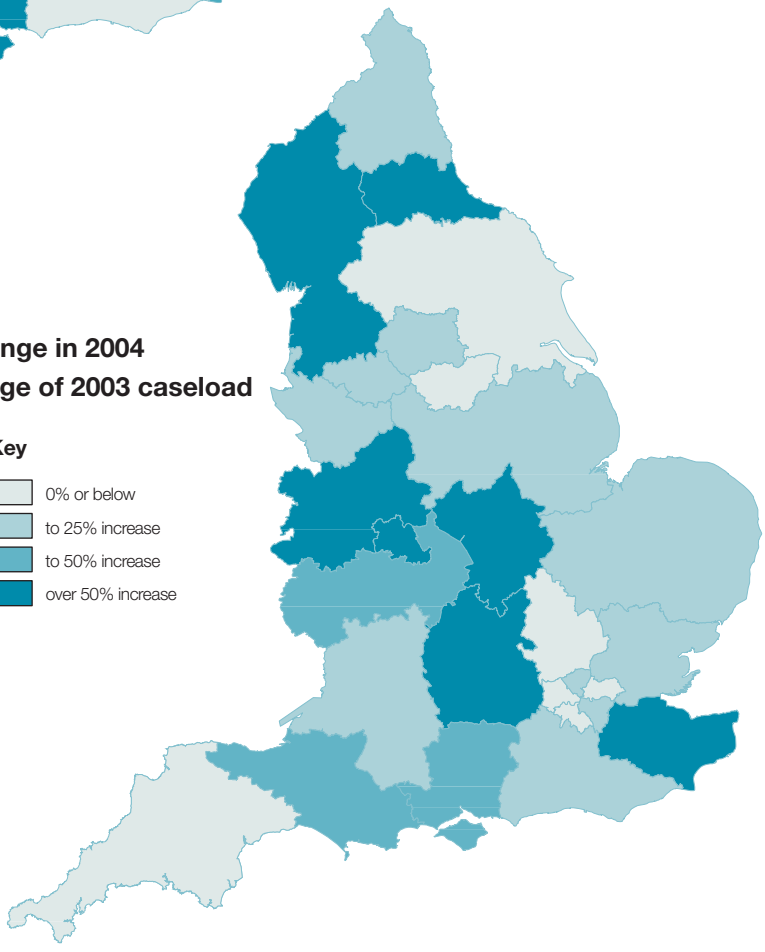
Despite the overall national increase, it was found that the scale of change in activity between 2003 and 2004 was patchy with some localities showing negative growth (Map 4.1b).



Map 4.1a: Caseload by 100k population aged 0-17 years old

Key

- Up to 747.49
- to 839.71
- to 926.86
- to 1040.07
- over 1040.07



Map 4.1b: Caseload change in 2004 as a percentage of 2003 caseload

Key

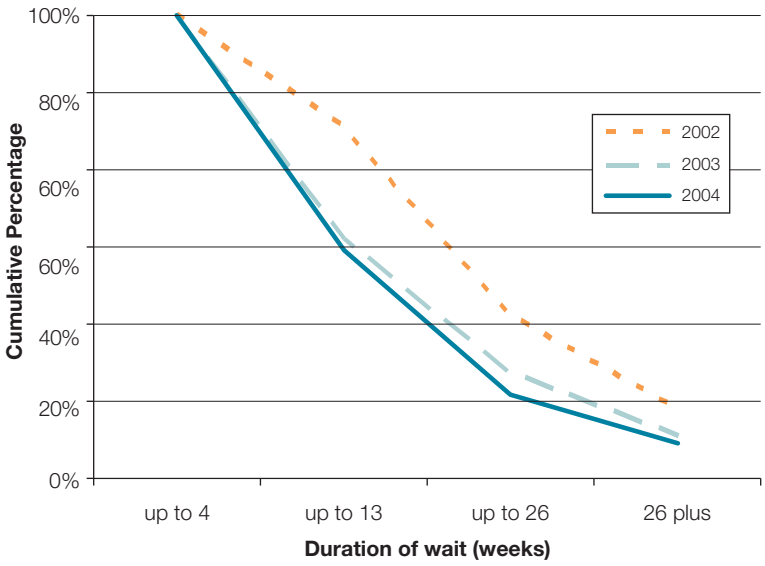
- 0% or below
- to 25% increase
- to 50% increase
- over 50% increase

4.2 New cases seen

New cases: A new case was an active case that had been seen for the first time during the data collection period.

Length of Wait: Duration of wait is the interval between the receipt of the referral request and the time the case is first seen. In the case of DNAs or cancellations, the wait is recorded from the most recent DNA or cancellation.

Fig. 4.2a: Percentage of new cases seen (cumulative totals)



In total there were 27,892 new cases reported in the 2004 exercise. This is an increase of 70.5% over 16,362 new cases reported in 2003. This was partly due to the increased caseload recorded in 2004 but the proportion of the caseload recorded as being 'new' increased from 12% in 2002 to 19% in 2003, and to 27% in 2004 confirming that the share of new cases in the total caseload was growing.

There were 25,020 new cases in tier 2/3 teams, and 2,872 new cases in tier 4 teams over the sample periods.

The majority of new cases (51%) were reported as having waited less than 4 weeks to be seen by a CAMHS team. This shows a continuation of the improvement in waiting times detected in the 2003 mapping when a wait of 4 weeks or less was experienced by 48% of new cases compared to 44% in 2002. The proportion of the caseload that had to wait up to 3 months increased slightly from 29% to 31% but slight improvements were apparent on waits up to 6 months. These were down from 14% to 11% of new cases. Waits over 6 months were similarly down from 9% in 2003 to 8% in 2005 (Fig. 4.2a).

The large increase in the number of new cases in the 12 months since the previous mapping, made it inevitable that the number (though not the proportion) of cases waiting, had also risen considerably. 14,119 cases had waited 4 weeks or less, 8,683 up to 3 months, 2,983 up to 6 months and 2,109 over 6 months.

The total tier 2/3 team caseload was 99,732 of which 25,020 cases (25%) were new in the study period. The variation between SHAs ranged from 26% to 63% of new cases. The average was 48% of cases seen in 4 weeks, 32% waiting up to 3 months, 12% waiting up to 6 months and 8% over 6 months. 5,012 cases were seen by tier

4 teams of which 2,872 were new cases (57%). It is clear from Fig. 4.2c that some SHAs can respond to demand for tier 4 services very quickly with no child waiting longer than 3 months. As a result, lengthy waits of over 6 months are very rare.

Fig. 4.2b: Length of wait for new cases accessing tier 2/3 teams.

(Figures in parentheses are rates of new cases per 100k 0-17).

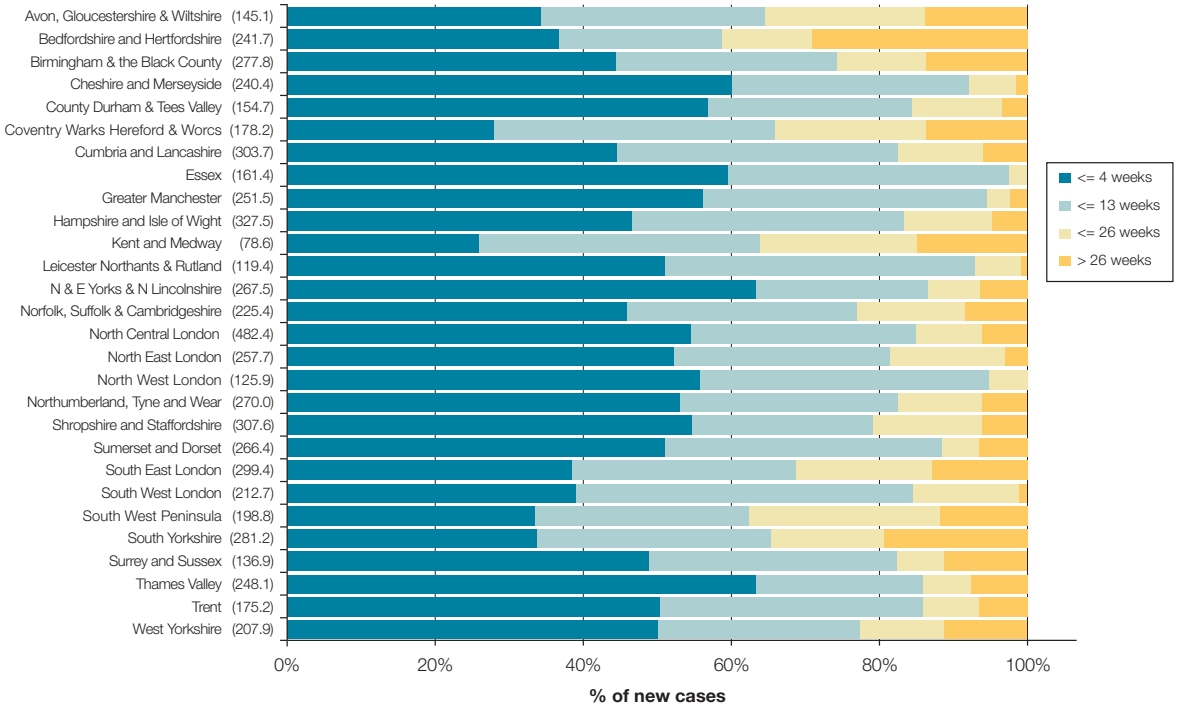
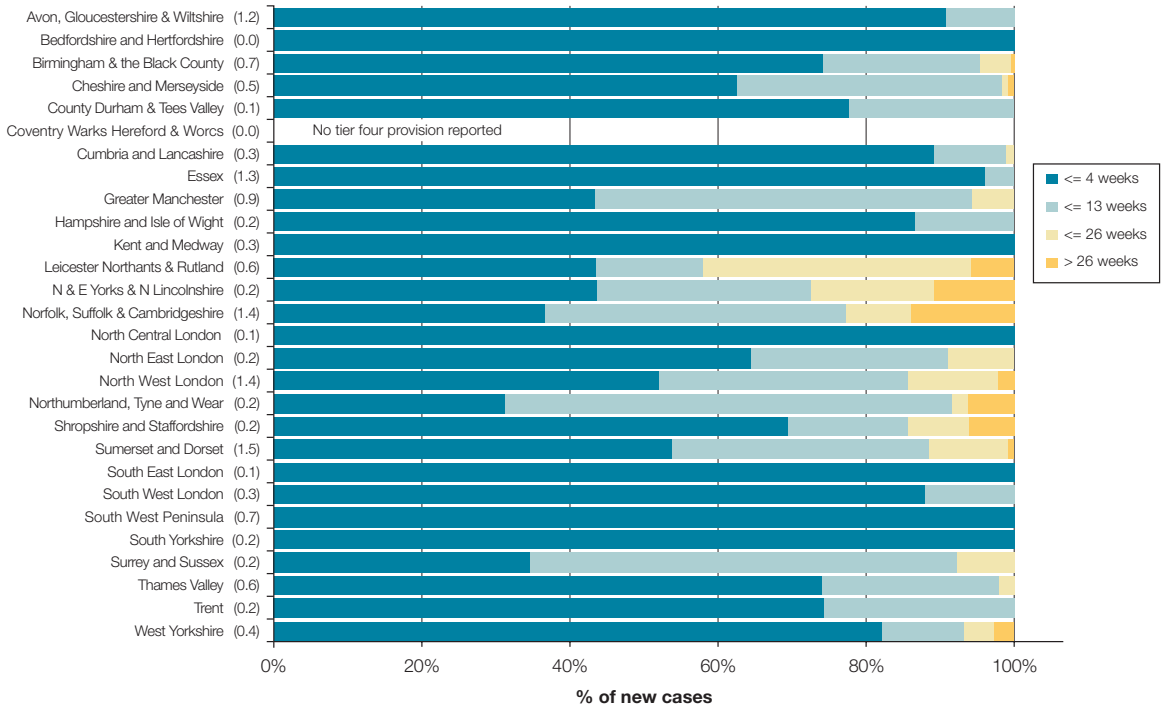


Fig. 4.2c: Length of wait for new cases to tier 4 teams.

(Figures in parentheses are rates of new cases per 100k 0-17).



4.3 Cases waiting and length of wait

At the end of the study period in 2004, CAMHS teams reported that there were 30,716 cases waiting to be seen nationally. This compares to 28,880 waiting at the same time in 2003, and 21,329 waiting in 2002. As a proportion of active caseloads this was 29% in 2004, 34% in 2003 and 27% in 2002 indicating that as the capacity of CAMH services has increased, the demand for services has grown faster.

The number of children and young people who had been waiting up to 4 weeks had increased from 8,049 in 2003 to 9,143 in 2004. The numbers waiting 4 to 13 weeks rose from 9,320 to 10,036 and the numbers waiting over 6 months rose from 5,261 to 6,134. Only the number of children waiting for between 3 to 6 months went down from 6,250 to 5,403. However, the pattern of waits for tier 2/3 and tier 4 teams was found to be very different (Fig. 4.3a and b).

Fig. 4.3a: Trend in cases waiting for 2/3 teams

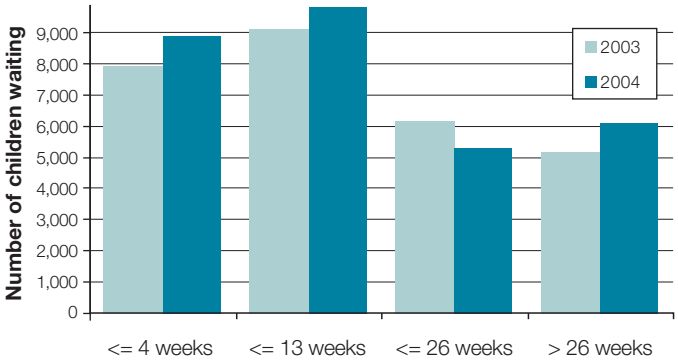
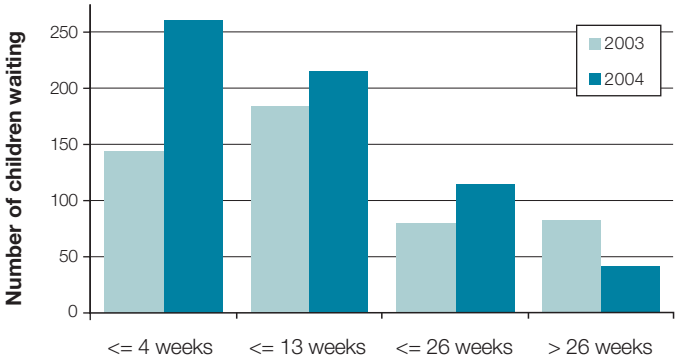


Fig. 4.3b: Trend in cases waiting tier 4 teams



The total number of cases waiting for tier 2/3 teams was 30,085, 30% of the active caseload. Of the caseload waiting, 29% had waited up to 4 weeks, 33% up to 3 months, 18% between 3 and 6 months and 20% over 6 months. Almost all SHAs had cases that had waited for 6 months or more (Fig. 4.3c).

Only 631 cases were waiting for tier 4 teams at the end of the study period emphasising the very specialist nature of these teams and the small number of referrals made to them. Predominantly waits were under 3 months (41% under 4 weeks and 34% 5-12 weeks). Only 6% of cases had waited over 6 months (Fig. 4.3d).

Fig. 4.3c: Length of wait for cases waiting tier 2/3 teams

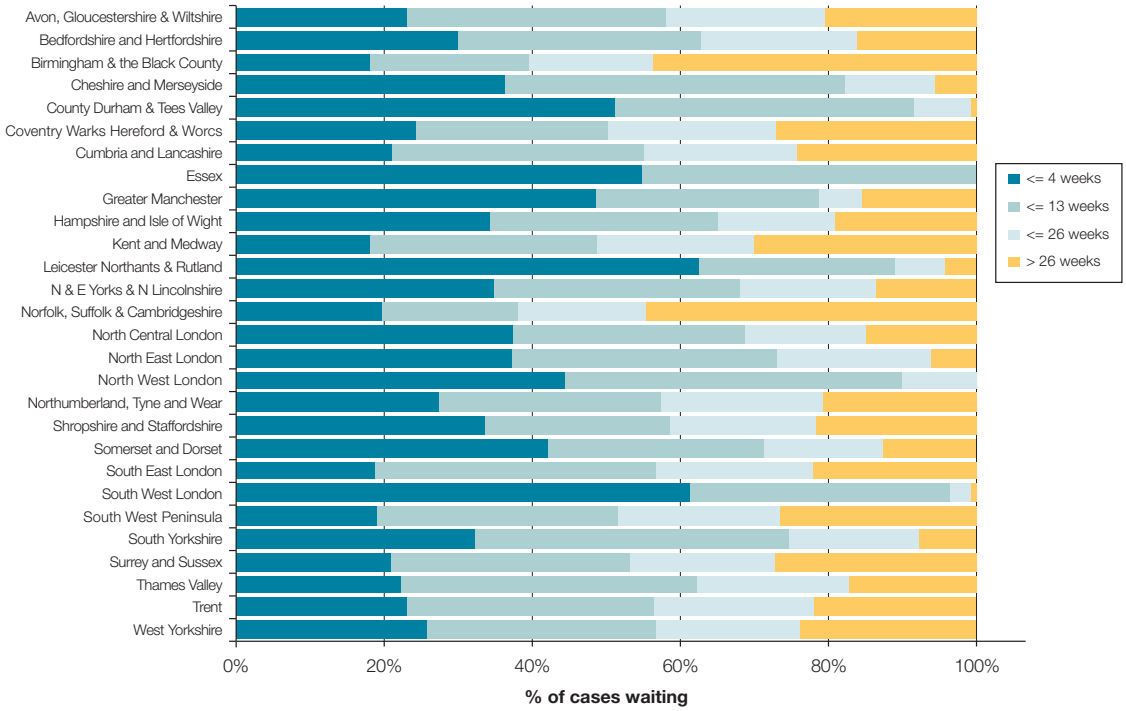
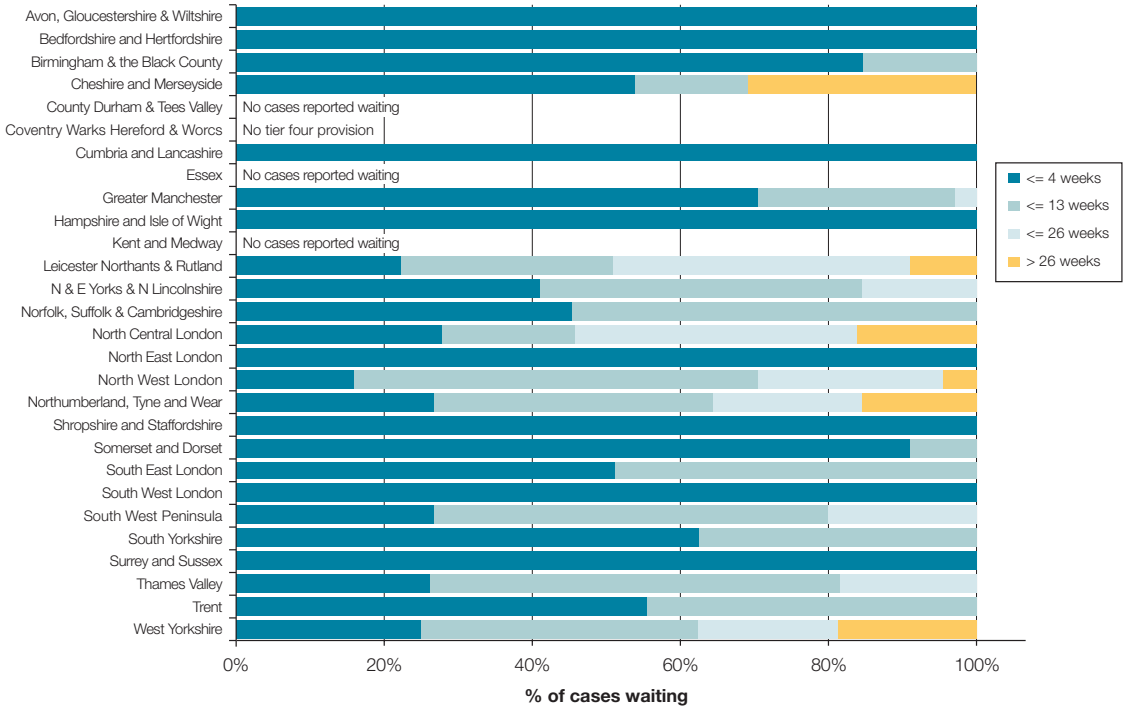


Fig. 4.3d: Length of wait for cases waiting tier 4 teams



4.4 Length of treatment

Duration of treatment measures how long a case has been seen for, or, if the case is closed in the sample period, how long that case was active. This is reported from the date of first work with the case up to the 30th November, or until the case was closed.

Information on the length of treatment was given for 101,501 cases overall – no data was given for 3,510 cases (3% of active caseload). Indications are that interventions are becoming longer (Fig. 4.4a and b). The proportion of the caseload which had been seen for 4 weeks or less decreased by 4% and the proportion having treatment of 1 to 3 months went down by 2%. The increase was all in the proportion of cases receiving treatment of 6 months or over.

Because evidence of this was collected in 2003, an additional category was added to the mapping in 2004 identifying treatment of over 1 year in length. It was found that 24% of active cases of tier 2/3 teams were of at least one year in duration and 18% of tier 4 teams.

Fig. 4.4a: Length of treatment in tier 2/3 teams

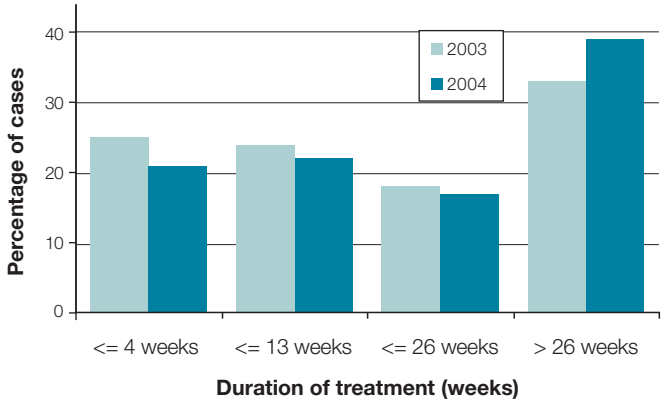
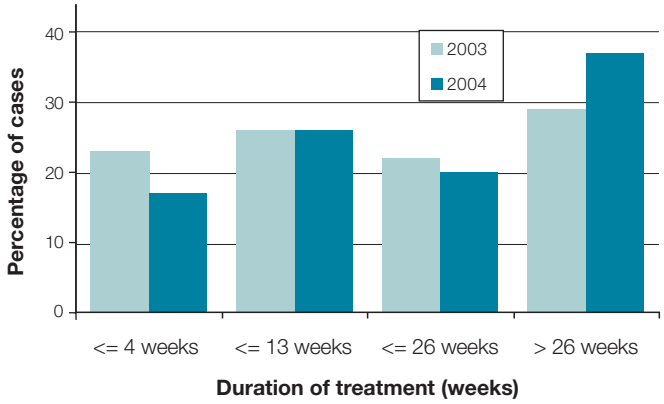


Fig. 4.4b: Length of treatment in tier 4 teams



A very even pattern of length of treatment can be seen throughout the country suggesting the approaches being taken to meeting the diverse needs of children and young people are being take nationally in generic, targeted and dedicated worker provision that make up tier 2/3 CAMHS teams (Fig. 4.4c). The length of treatment provided by tier 4 teams was more variable across SHAs reflecting the differing nature and location of tier 4 teams (Fig. 4.4d).

Fig. 4.4c: Length of treatment in tier 2/3 teams

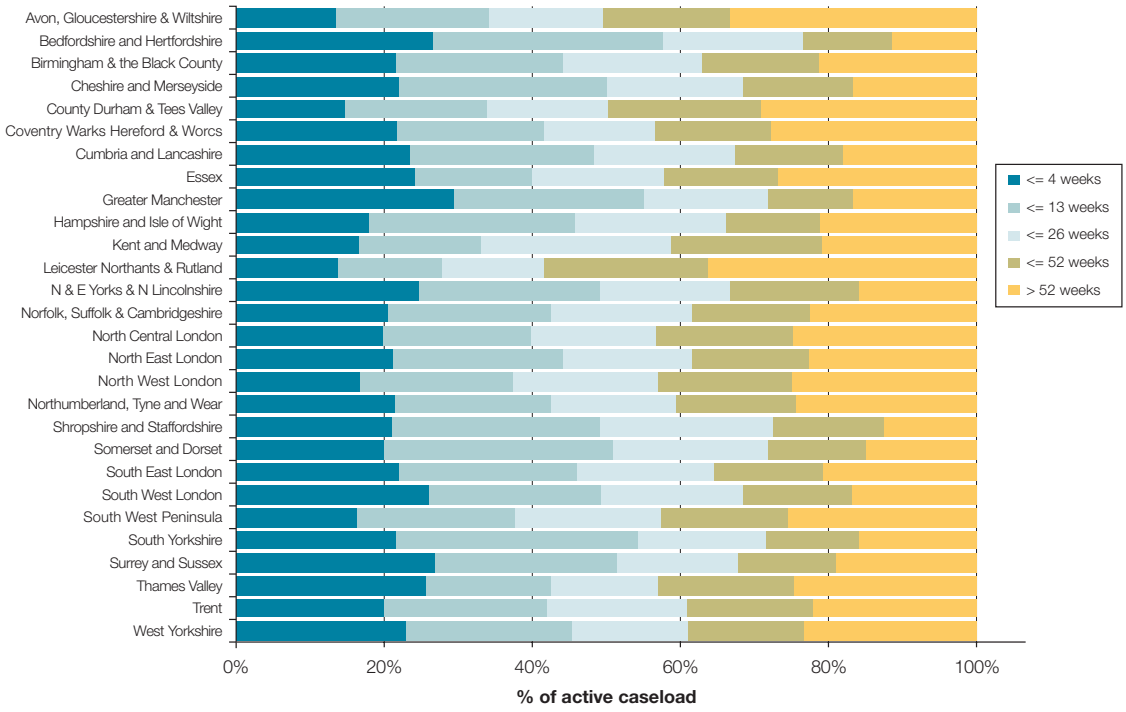
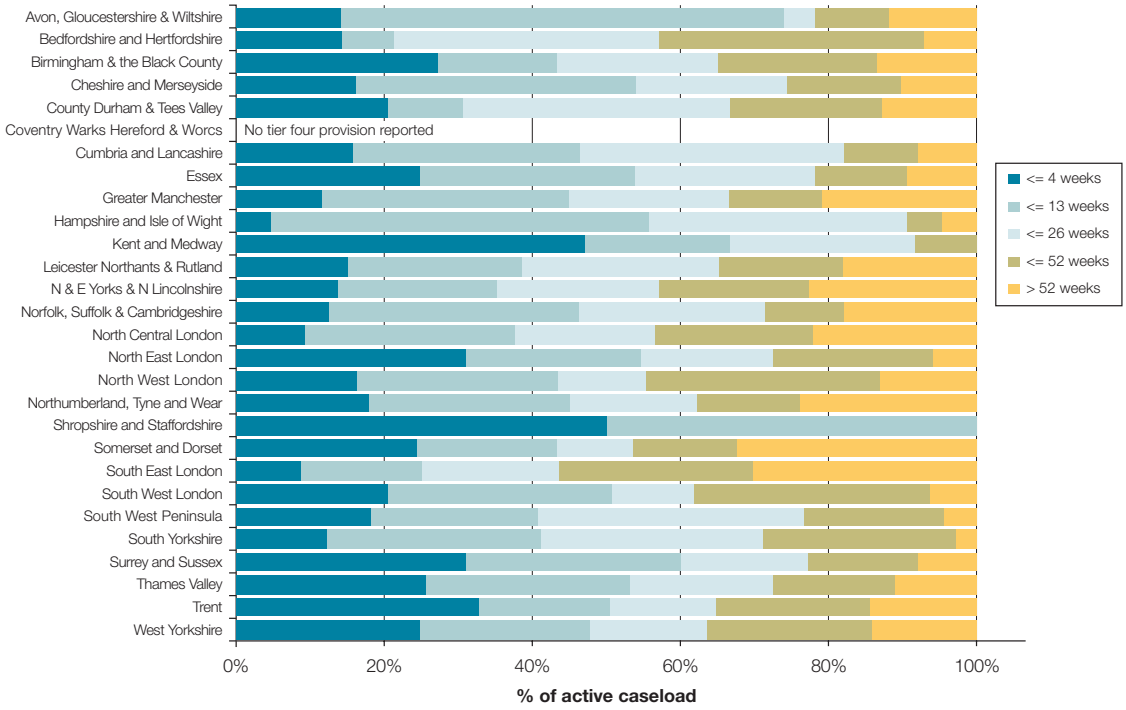


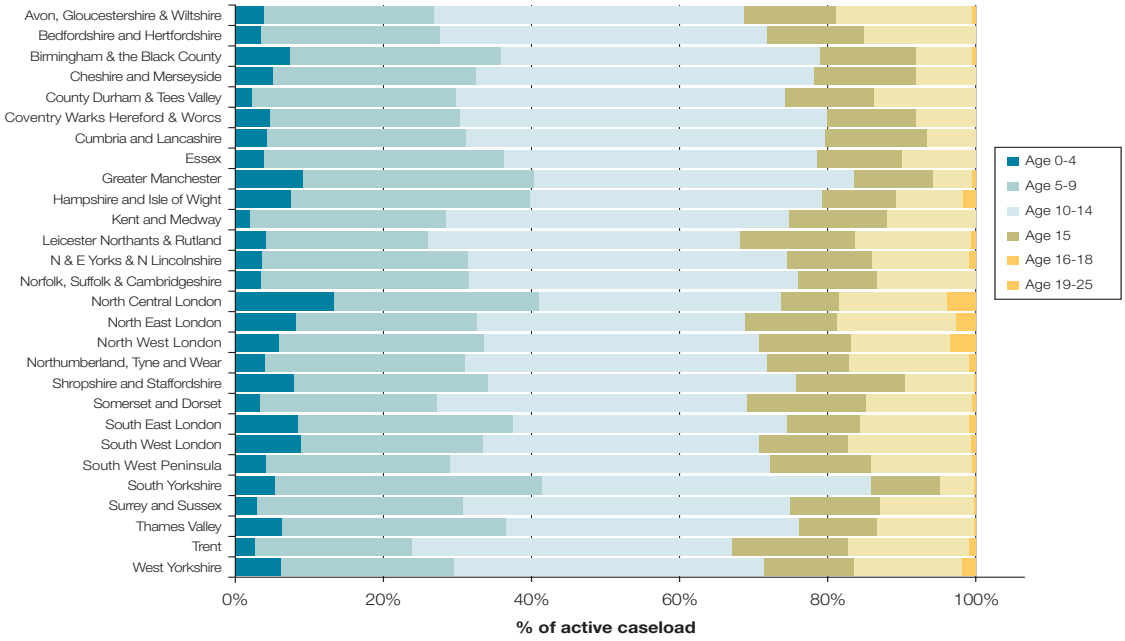
Fig. 4.4d: Length of treatment in tier 4 teams



4.5 Age and Gender Profile

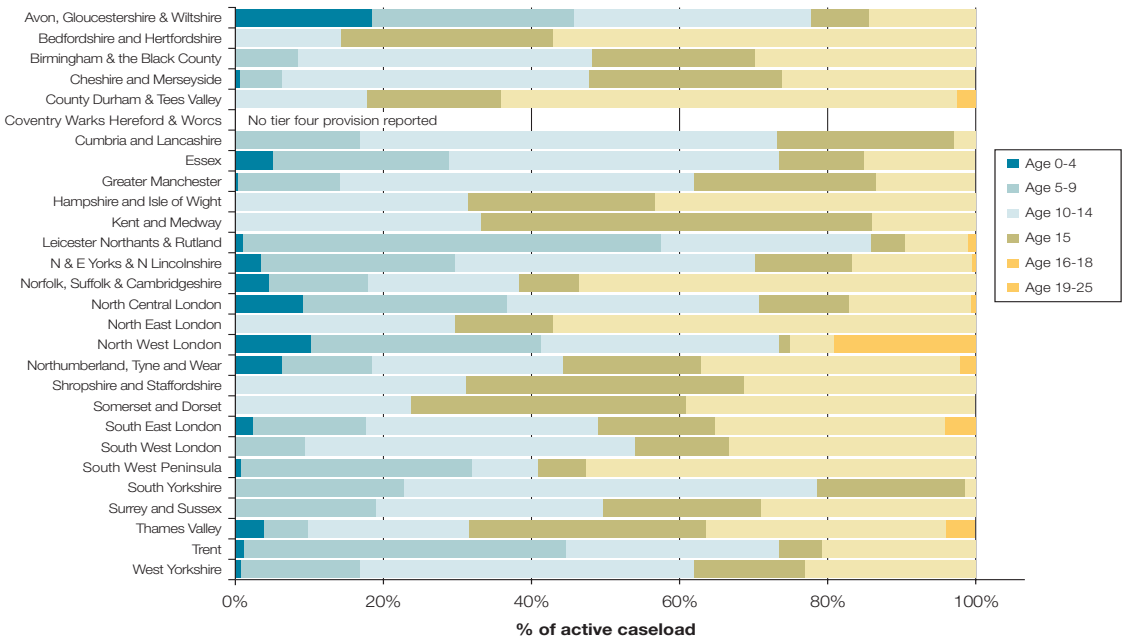
There was very little change in the age profile of children and young people using CAMHS services in 2004 from the previous year. In tier 2/3 teams the proportion of young people aged increased from 40 % to 42% and the proportion aged 16 and 17 rose from 11% to 12%. The between SHAs in the age range of service users of tier 2/3 teams was small (Fig. 4.5a).

Fig. 4.5a: Age profile of users of tier 2/3 team (N=90,102)



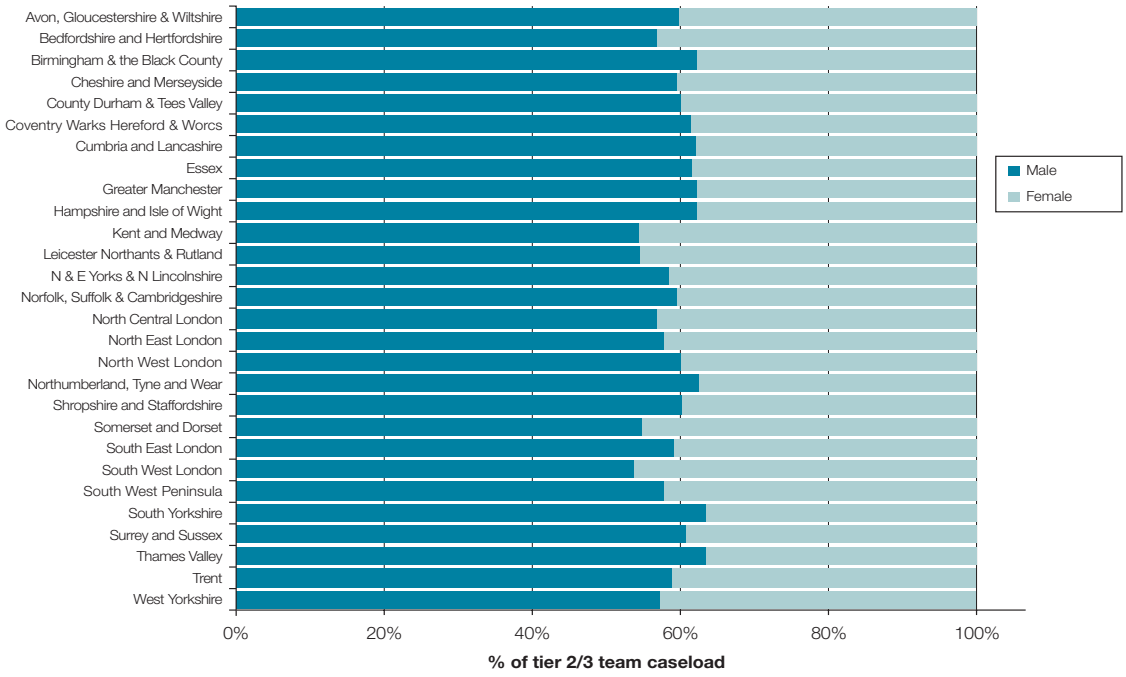
The age profile of service users of tier 4 teams by SHA was found to be very different from that of tier 2/3 teams (Fig. 4.5b). The nature of these specialist services may dictate the age of the children and young people using them. In particular the emphasis on adolescent provision can be seen in some localities.

Fig. 4.5b: Age profile of users of tier 4 teams (N=4,531)



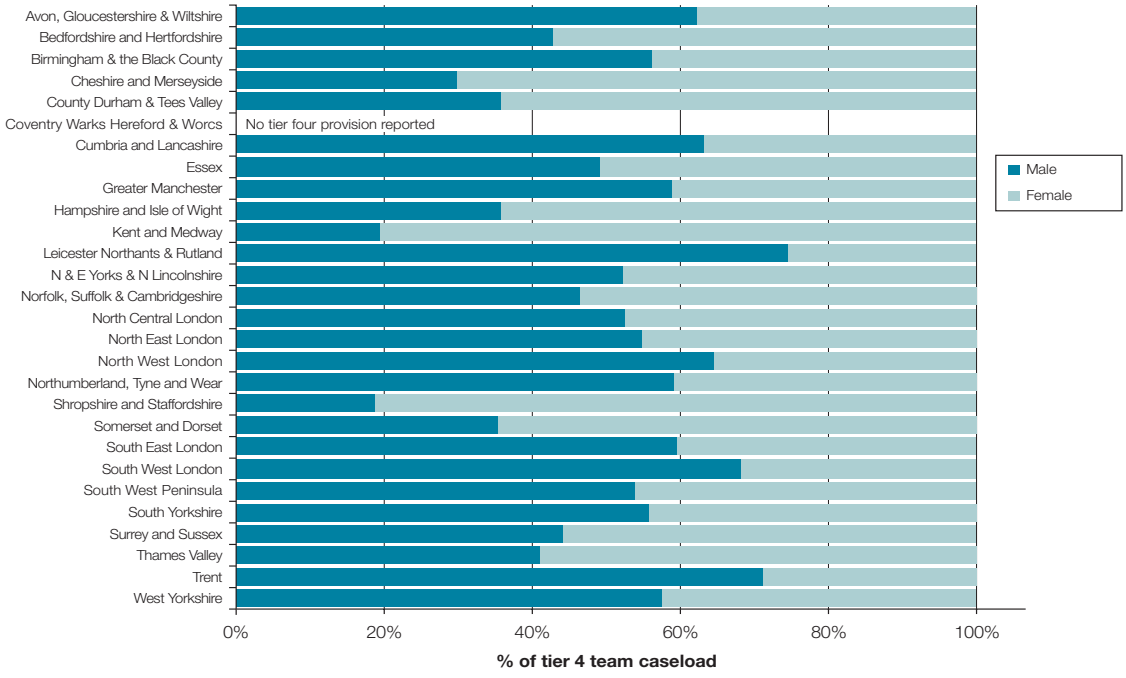
Overall 60% of the children and young people using tier 2/3 teams were male and the gender profile by SHA was remarkably consistent nationally (Fig. 4.5c).

Fig. 4.5c: Gender of service users of tier 2 to 3 teams (N=90,102)



The gender profile of tier 4 team service users was more variable. This reflected the provision in SHAs of services, such as those for eating disorders, which tend to have a more gender specific client group. Overall, 54% of tier 4 users were male (Fig. 4.5d).

Fig. 4.5d: Gender of service users of tier 4 teams (N=4,531)



4.6 Ethnicity

Very little change from the previous year was found in the ethnic profile of the children and young people using CAMH services. 81% of cases were white British, a reduction of 5% from 2003 in the observed figure, but the comparison is not simple as the method of recording changed.

There do not appear to be any black or minority ethnic communities (BME) that used services more in 2004 (Fig. 4.6a & b). In fact there could have been a slight reduction in the number of BME cases, especially in tier 4 teams.

Overall, of the 19% BME cases, 4% came from mixed groups, 3% from Asian and Asian British communities, 3% from Black and Black British communities and less than 1% from Chinese communities.

Fig. 4.6a: Ethnicity of tier 2/3 team cases

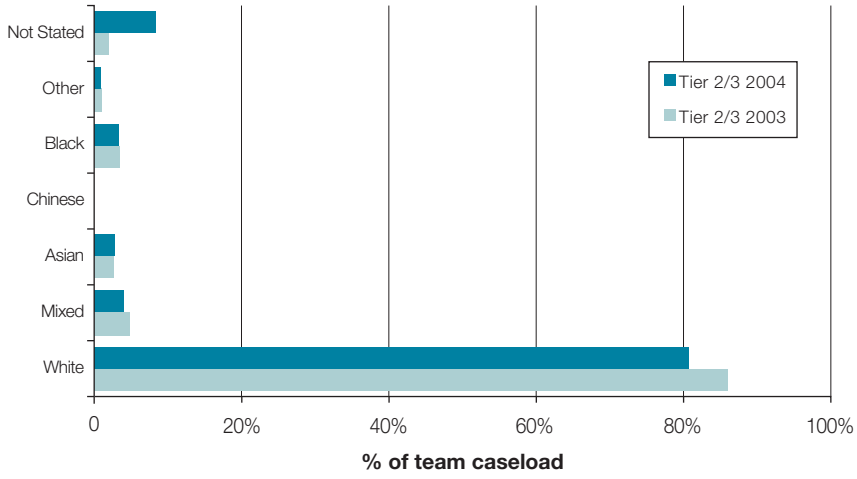


Fig. 4.6b: Ethnicity of tier 4 team cases

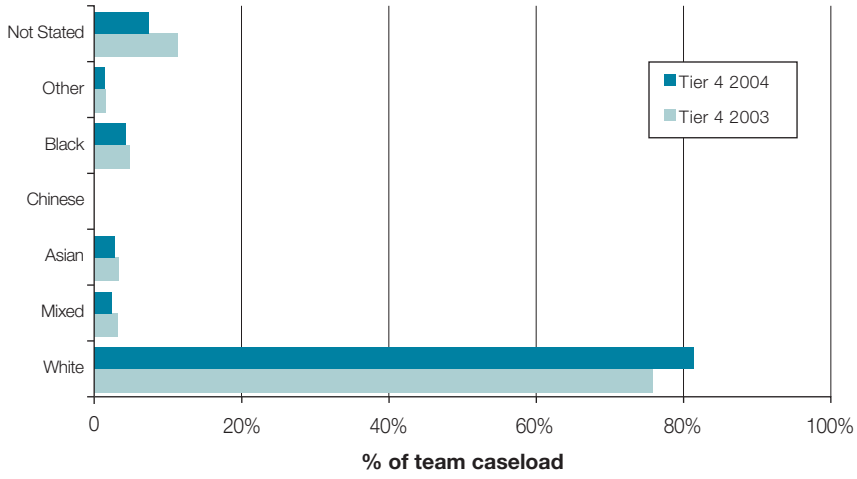


Fig. 4.6c: Ethnicity of service users in tier 2 to 3 teams (N=90,365)

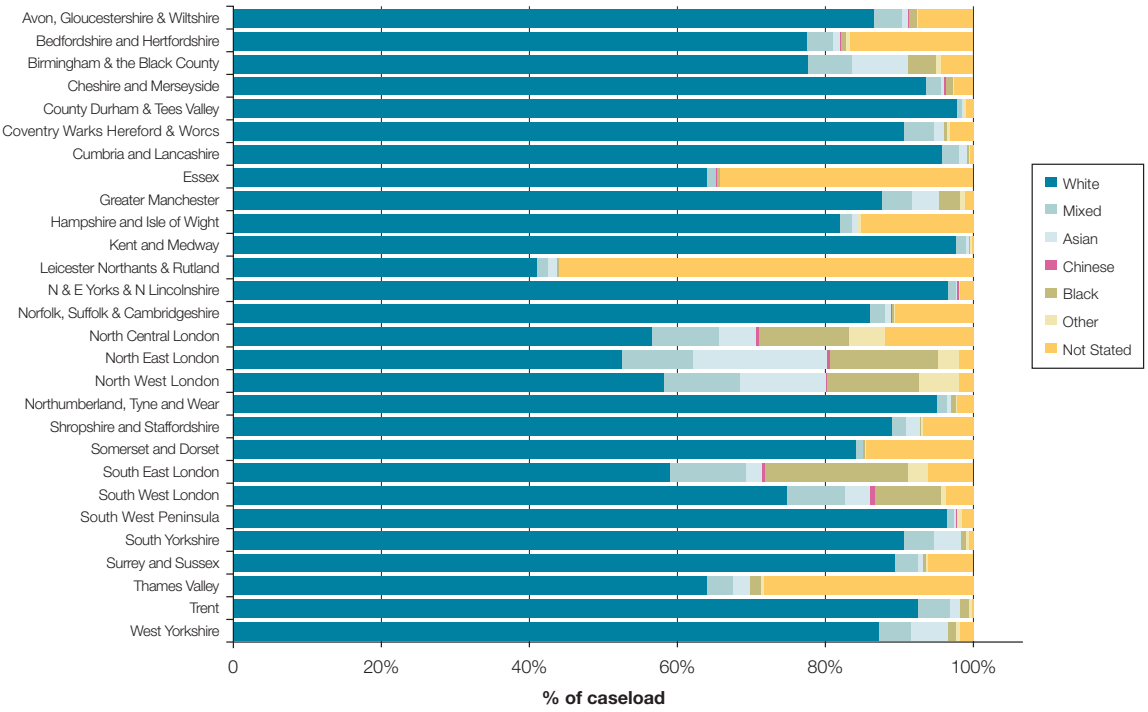
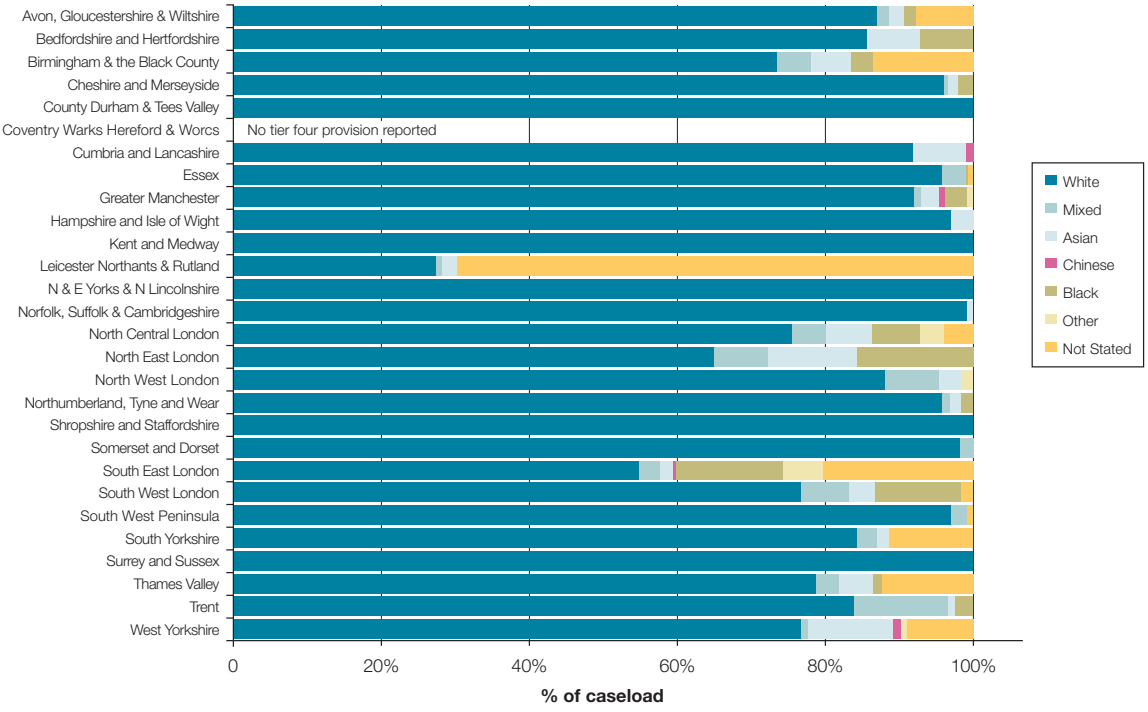


Fig. 4.6d: Ethnicity of service users in tier 4 teams (N=4,599)



4.7 Primary Presenting Disorder

The most common primary presenting disorder was emotional disorder accounting for 28% of cases. Conduct disorder and hyperkinetic disorder remained the next most common reasons for referral (Fig. 4.7a and b).

Fig. 4.7a: Primary presenting disorder of service users of tier 2 to 3 teams (N=116,788)

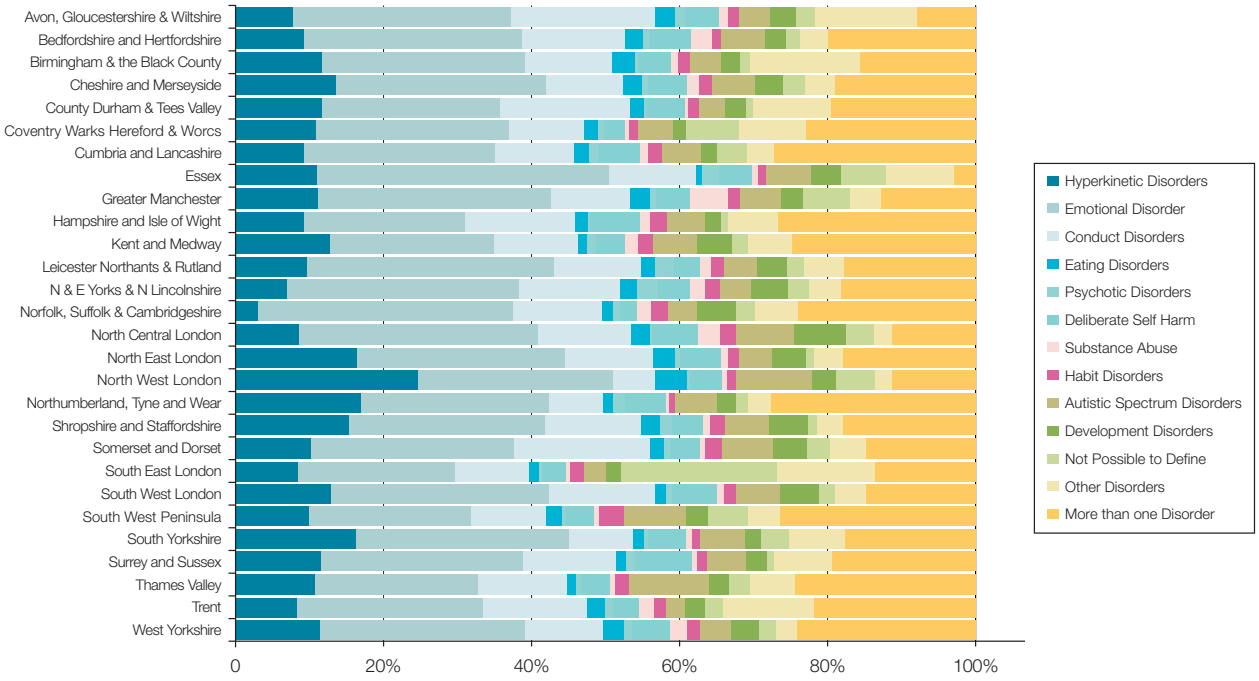
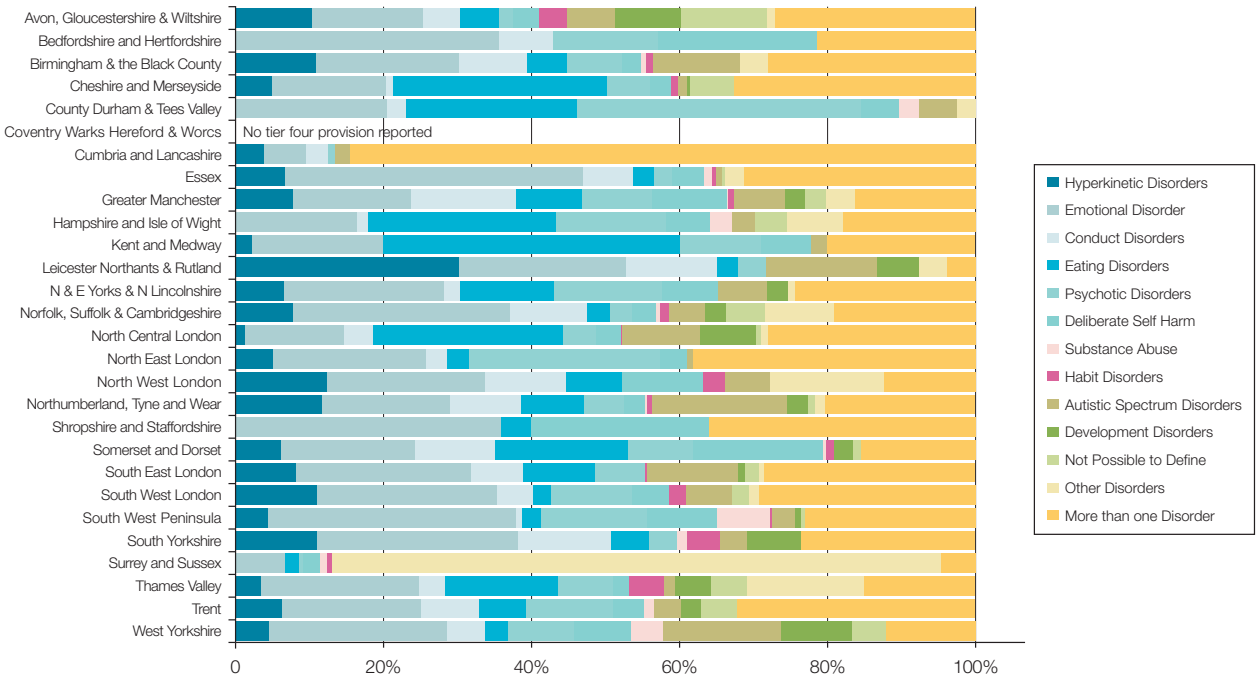


Fig. 4.7b: Primary presenting disorder of service users of tier 4 teams (N=6,108)



4.8 Referral source

Most referrals to tier 2/3 teams came from primary care, child health and education sources (Fig 4.8a). Tier 4 referrals tended to be from other trusts and other CAMHS teams (Fig. 4.8b).

Fig. 4.8a: Referral source of service users of tier 2 to 3 teams (N=92,714)

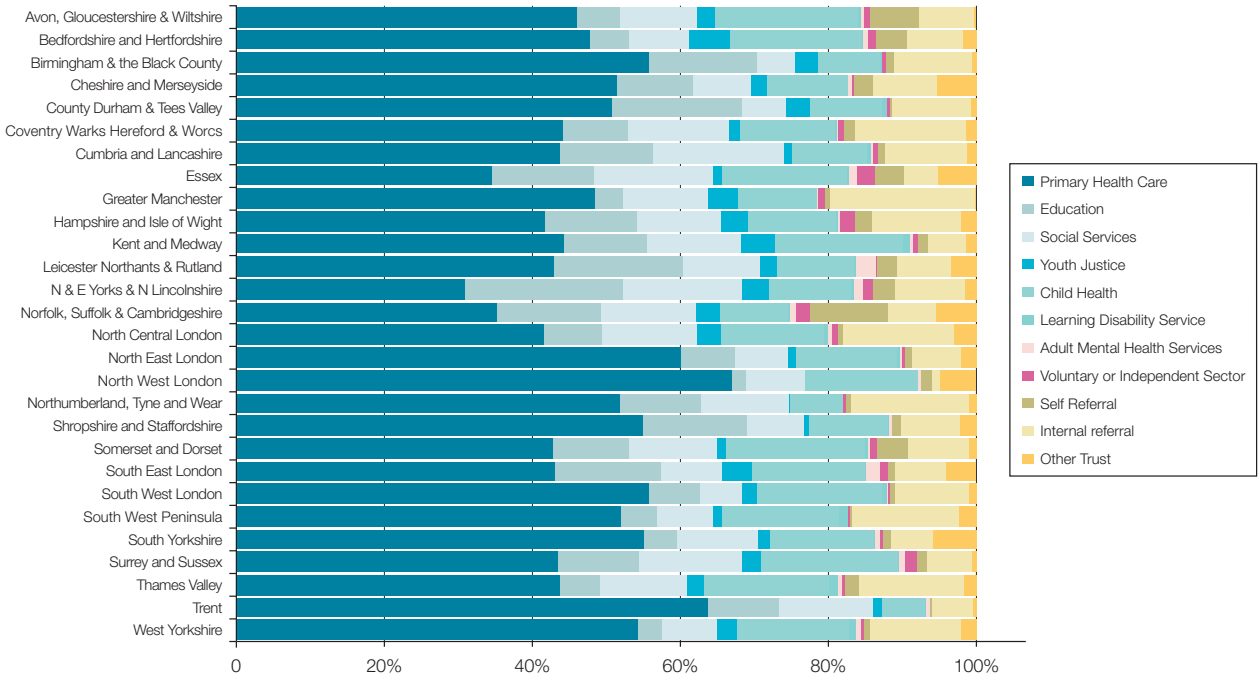
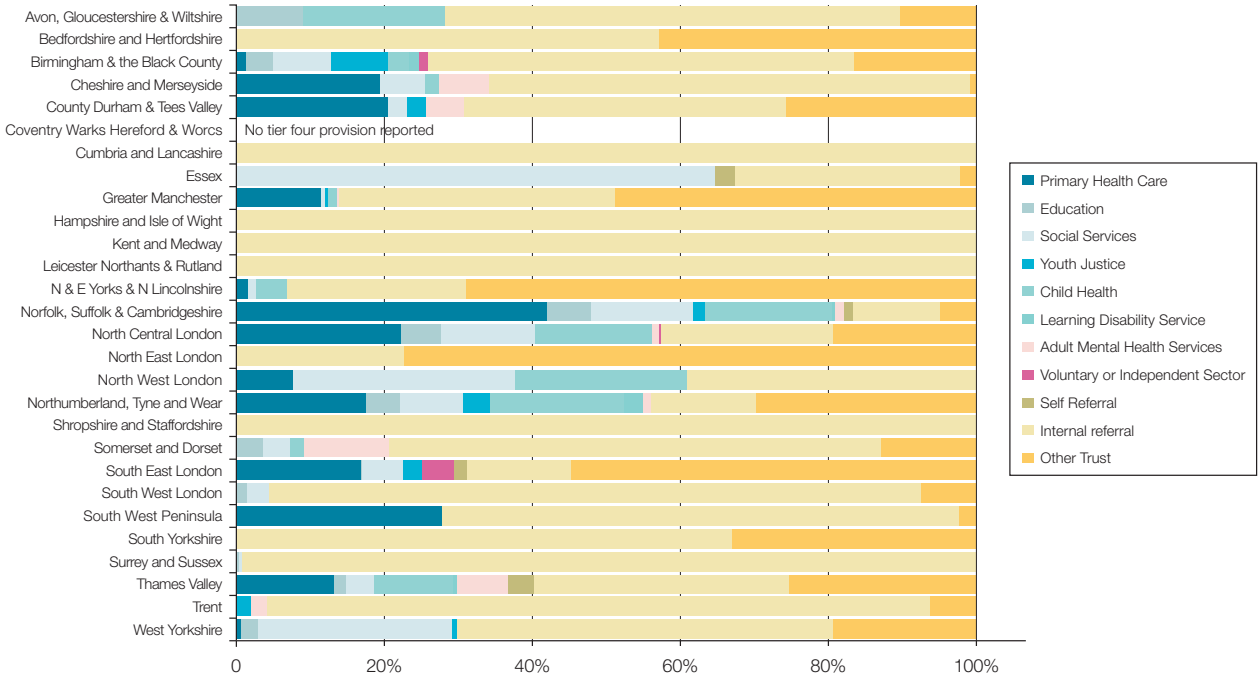


Fig. 4.8b: Referral source of service users of tier 4 teams (N=4,930)



Chapter 5:
Workforce

This chapter summarises information provided on the workforce of specialist CAMH sections on:

Detailed tables of the data used in the following chapter can be found on the CAMHS at:

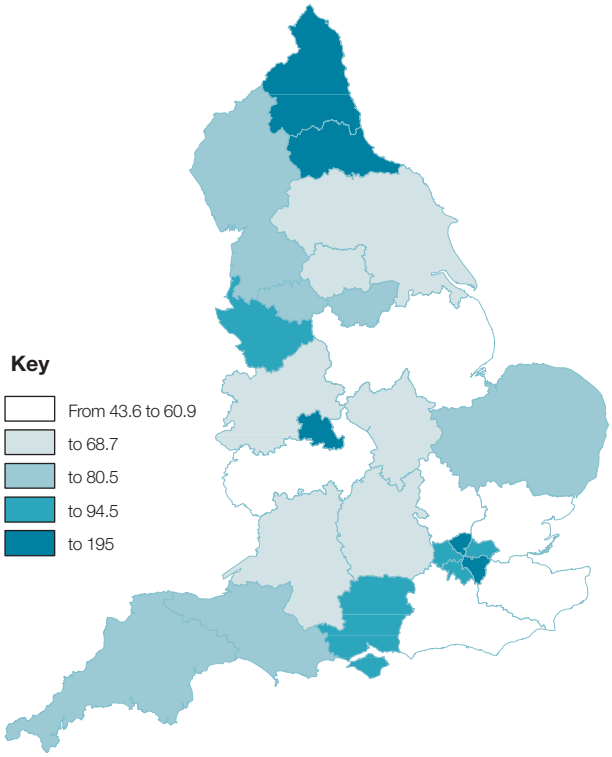
www.camhsmapping.org.uk/2004

All figures and maps correspond to tables of the same number on the website.

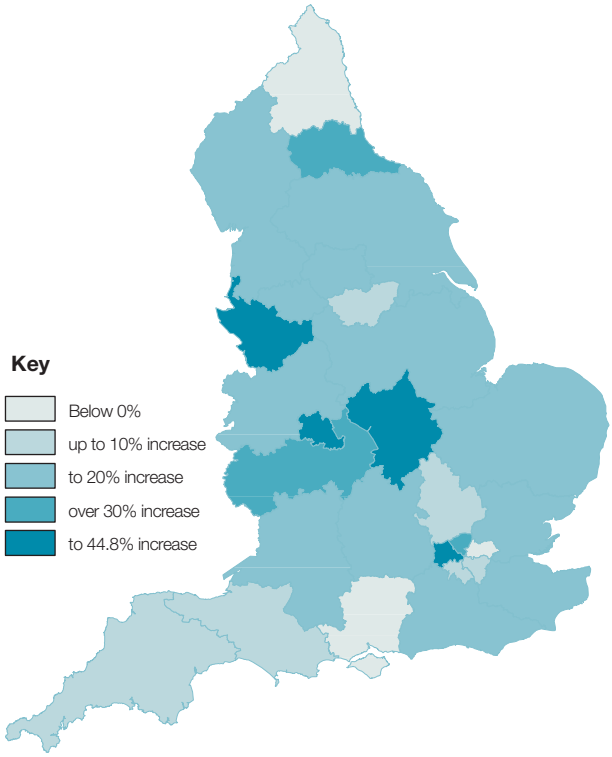
5.1 CAMHS workforce overview

The total CAMHS workforce in November 2004 was 8,294 WTE staff. The workforce per 100k population of 0-17 year olds is unevenly distributed across the country (Map 5.1a) but is 80.4 WTE staff per 100k on average. SHA variation ranges from 45.5 to 195.

Map 5.1a: 2004 workforce per 100k population



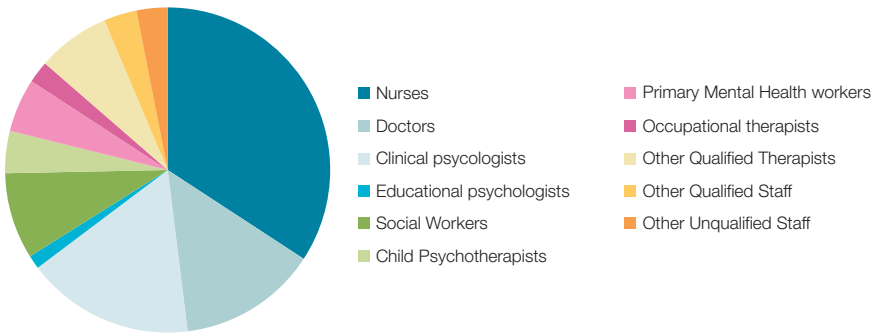
Map 5.1b: Change in 2004 workforce as percentage of 2003 workforce



Between 2003 and 2004, the workforce grew by 15%. In some areas it increased as much as 40% whilst other areas reported a decrease up to 5% (Map 5.1b).

The largest professional group is nurses who make up 28% of the workforce. The other two substantial groups are doctors (11%) and clinical psychologists (14%) (Fig. 5.1a).

Fig. 5.1a: Total workforce by profession



Definitions of local and wider teams

Local teams:

A local team is one that has been commissioned to serve a defined local area. These are usually made up of a single, or small number of, PCTs and/or local authorities. Almost all children and young people using a local team will come from this area but it is acknowledged that local teams will also occasionally support clients from further a field.

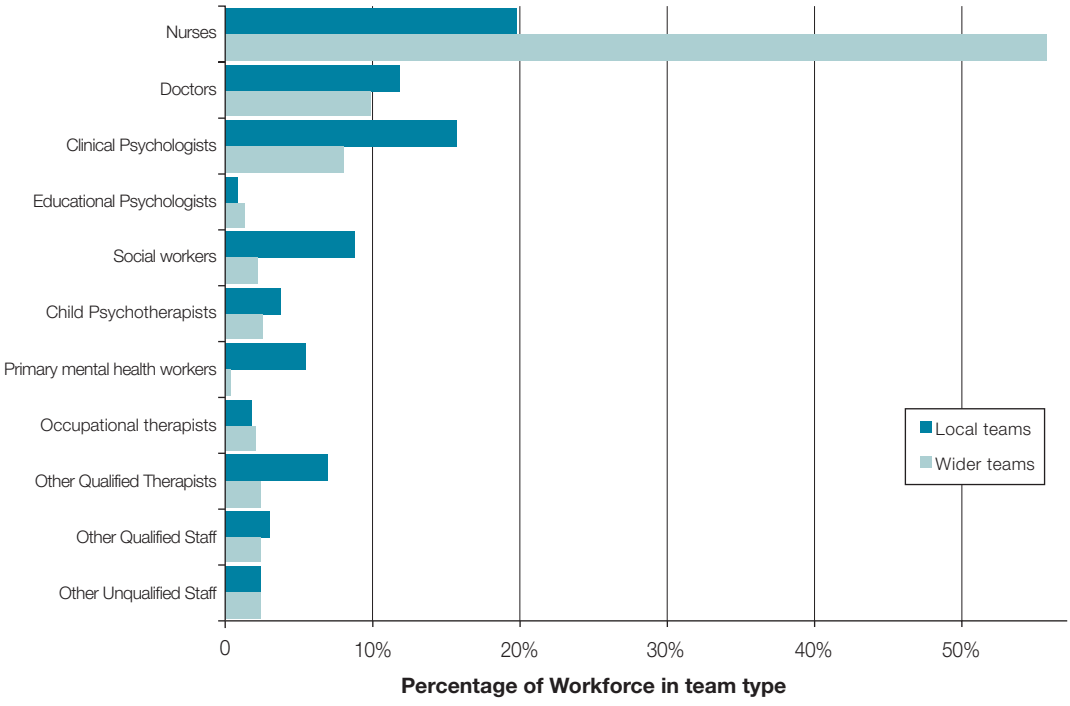
Wider than local teams:

A wider than local team will have commissioning arrangements to serve an area best described in terms of Strategic Health Authorities (SHAs). These can be national services providing specialist provision for the whole of England.

Throughout the atlas reference has been made to local and wider teams (see definitions). In this chapter these categories are used to distinguish between staff that work in teams that provide for a local population and those who work in teams which serve large catchment areas, such as a number of SHAs. This is because the areas served by wider teams are harder to define, and therefore it is not possible to map the workforce of these teams to population.

The difference in the workforce of wider and local teams is particularly evident with respect to nurses, who dominate the staffing of wider teams (58%). The reason for this is that the majority of tier 4 provision, including inpatient care, is in wider than local teams (Fig. 5.1b).

Fig. 5.1b: Percentage of workforce in local and wider teams by profession

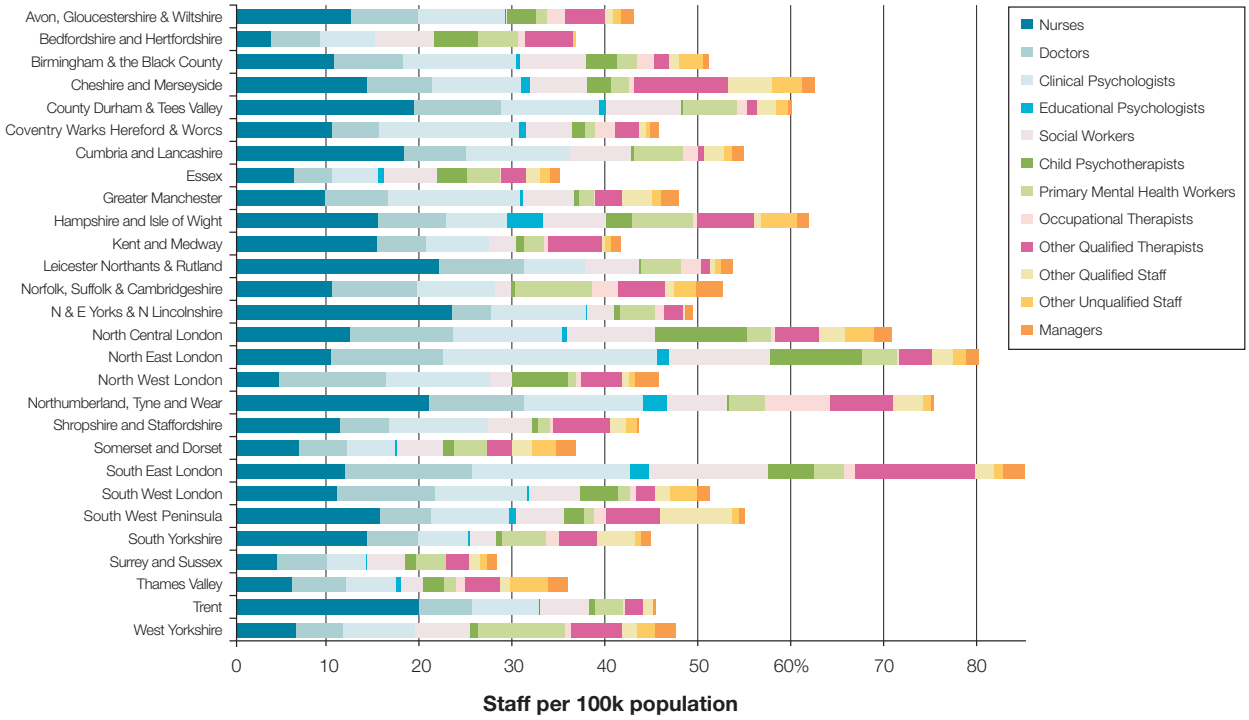


5.2 Workforce patterns within local teams

The majority of CAMHS staff work in local teams that have been developed to meet the needs of a specific local population. In total, 6,778 WTE staff are employed in local teams, 76% of the total CAMHS workforce.

Nurses made up 20% of the local team workforce but there was considerable variation nationally with the highest nurse provision in the east and north east of the country (see Map 5.2a). On average there were 12 WTE nurses per 100k population (aged 0-17) but this varied by SHA between 23.4 to under 4 nurses per 100k population aged 0-17 (Fig. 5.2).

Fig. 5.2: Local teams - staff per 100k population by profession



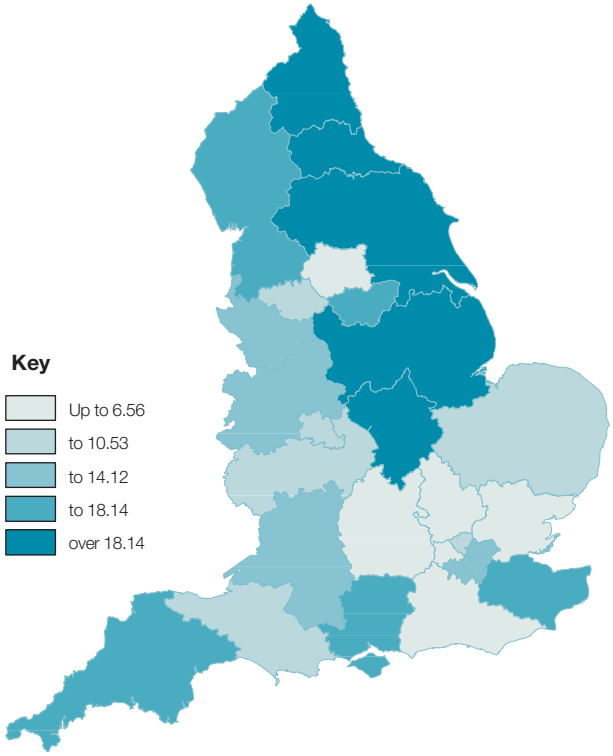
Clinical psychologists made up the next largest professional staff group in local CAMHS teams providing 16% of the workforce. Overall there were 9.6 WTE clinical psychologists per 100k population but this ranged from 23 to 4.4. The very patchy national provision is shown in Map 5.2c.

Doctors made up 12% of the local team workforce with 798.7 WTE in total. Provision varied from 13.7 to just over 4 per 100k population. On average there were 7.2 doctors per 100k population with the highest provision overall in London (Map 5.2b)

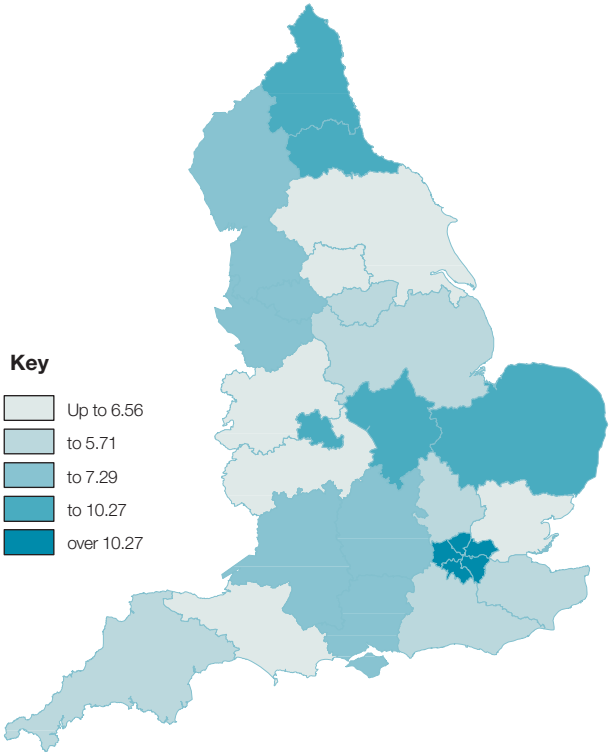
The social work workforce was considerably smaller at 592.9 WTE. This was 9% of the total staffing of CAMHS local teams. There was a national average of 5.35 WTE social worker per 100k population. However, the accuracy of the data must be questioned as the SHA rate of social worker to 100k population ran from 0.2 to 12.9.

The provision of child psychotherapists also showed considerable SHA variation with one SHA employing none. On average there were 2.3 WTE child psychotherapists per 100k population but provision was concentrated in London and the south (Map 5.2d).

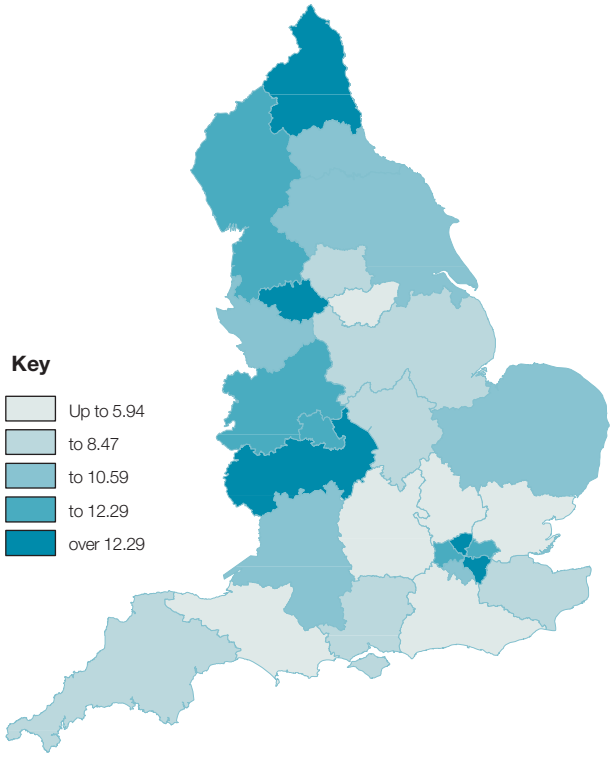
Map 5.2a: Nurses per 100k population in local teams



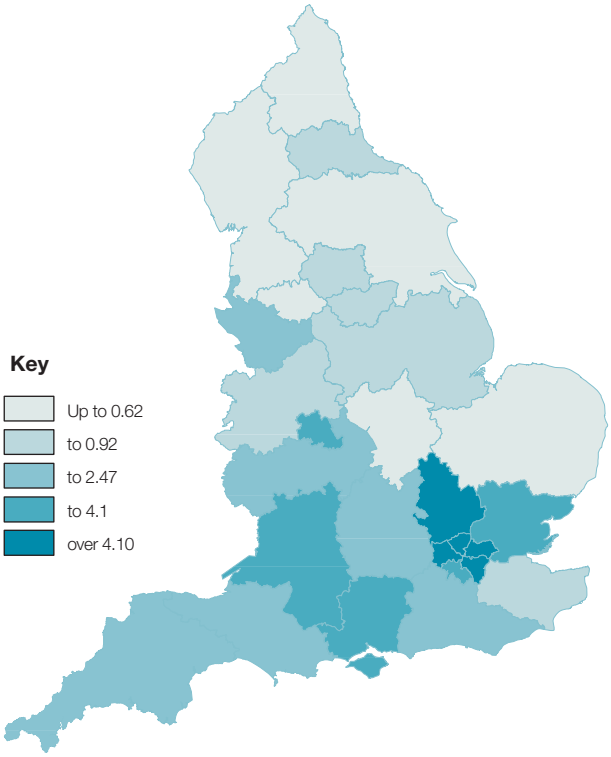
Map 5.2b: Doctors per 100k population in local teams



Map 5.2c: Clinical psychologists per 100k population in local teams



Map 5.2d: Child psychotherapists per 100k population in local teams



The CNSF estimated local requirements for Tier 3 care staff in relation to numbers in the whole population rather than that aged 0-17. It considered 20 WTE care staff in teaching, and 15 in nonteaching services a minimum per 100k population. In the mapping terms, 'local' services would cover both tiers 2 and 3 (as described in the CNSF). Table 5.1 shows the numbers of local care staff reported per 100k total SHA populations for comparison with this yardstick.

Table 5.2 Care staff in local teams per 100k total population for comparison with CNSF estimate of Tier 3 requirements.

SHA	Care Staff
Avon, Gloucestershire & Wiltshire	8.8
Bedfordshire and Hertfordshire	7.6
Birmingham & the Black Country	11.8
Cheshire and Merseyside	13.3
County Durham & Tees Valley	12.0
Coventry Warks Hereford & Worcs	10.2
Cumbria and Lancashire	10.3
Essex	6.8
Greater Manchester	10.3
Hampshire and Isle of Wight	11.7
Kent and Medway	8.8
Leicester Northants & Rutland	11.0
Norfolk, Suffolk & Cambridgeshire	9.7
N & E Yorkshire & N Lincolnshire	8.9
North Central London	16.1
North East London	16.3
North West London	8.6
Northumberland, Tyne and Wear	15.1
Shropshire and Staffordshire	9.3
Somerset and Dorset	6.5
South East London	17.7
South West London	10.2
South West Peninsula	10.9
South Yorkshire	8.7
Surrey and Sussex	5.1
Thames Valley	7.4
Trent	9.1
West Yorkshire	8.4
Total	**10.2**

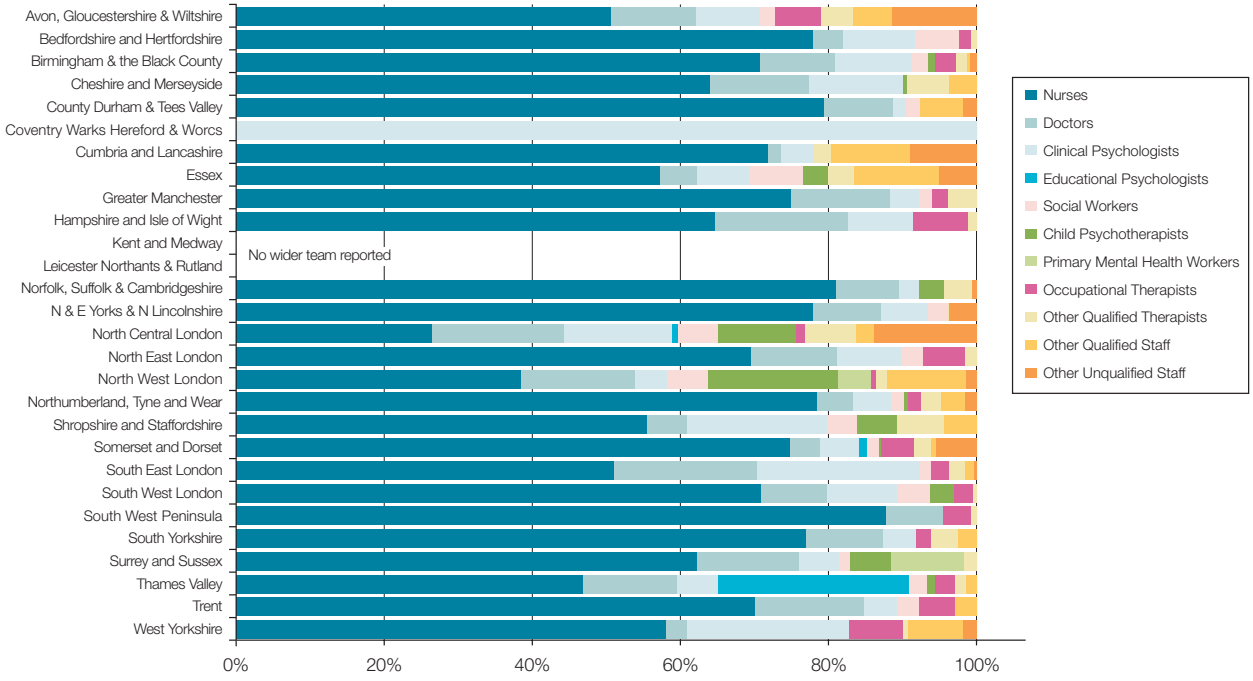
5.3 Workforce in wider than local teams

Wider than local teams tend to be, but are not exclusively, tier 4 teams. They are usually small specialist units, and because of their different specialisms, there was no common pattern in the professional make up of the workforce. In total, 24% of the CAMHS workforce was employed in wider than local teams and as expected, the variation across the country was very marked (Fig. 5.3). Two SHAs did not report any wider than local team provision and one SHA reported only one clinical psychologist as wider than local.

As has been explained above, wider than local teams cannot be examined against specified populations. Therefore the professional make-up of the workforce has been examined in terms of percentages of total staffing. However, the percentages should be considered in terms of the total workforce size as these range from 276 to less than 30. Overall, 56% of the workforce was nurses, reflecting the dominance of inpatient provision.

Fig. 5.3: Workforce in wider teams

(WTE staff in wider teams per 100k 0-17 in parentheses)



5.4 Specialist CAMHS (Tiers 2-4) Support to Tier 1

Definitions:

PMHW:
Primary Mental Health Workers (PMHW) are specialist child and adolescent mental health workers, providing an early intervention interface between tier 1 and specialist CAMHS. They also work on the promotion of mental health in children and provide direct intervention with children, young people and families, usually working jointly with tier 1 professionals.

Support to Tier 1:
All staff were asked to record time spent in working with Tier 1. This includes workers providing a combination of support, advice, consultation, supervision and training to tier 1 professionals on emerging mental health needs in children and young people.

In the 2004 CAMHS mapping exercise, primary mental health workers (PMHW) were identified as a professional group for the first time. In total 381.7 WTE PMHW were recorded in the workforce.

All staff were also asked to estimate the time spent supporting tier 1 work. This equated to 7.5% of total staff time nationally. Total time spent per professional group was 10.5% for Clinical Psychologists, 7.6% for nurses, 6.5% for social workers and 4.5% for doctors. Fig. 5.4a shows these proportions nationally, Fig. 5.4b shows the pattern of variation around the country.

Fig. 5.4a: Proportion of total time supporting tier 1 contributed by each professional group

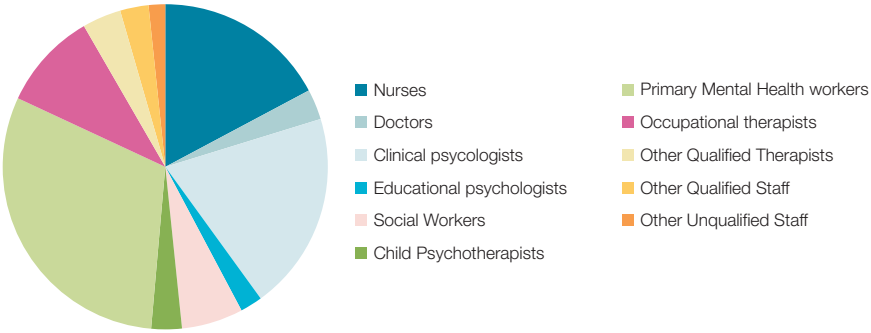
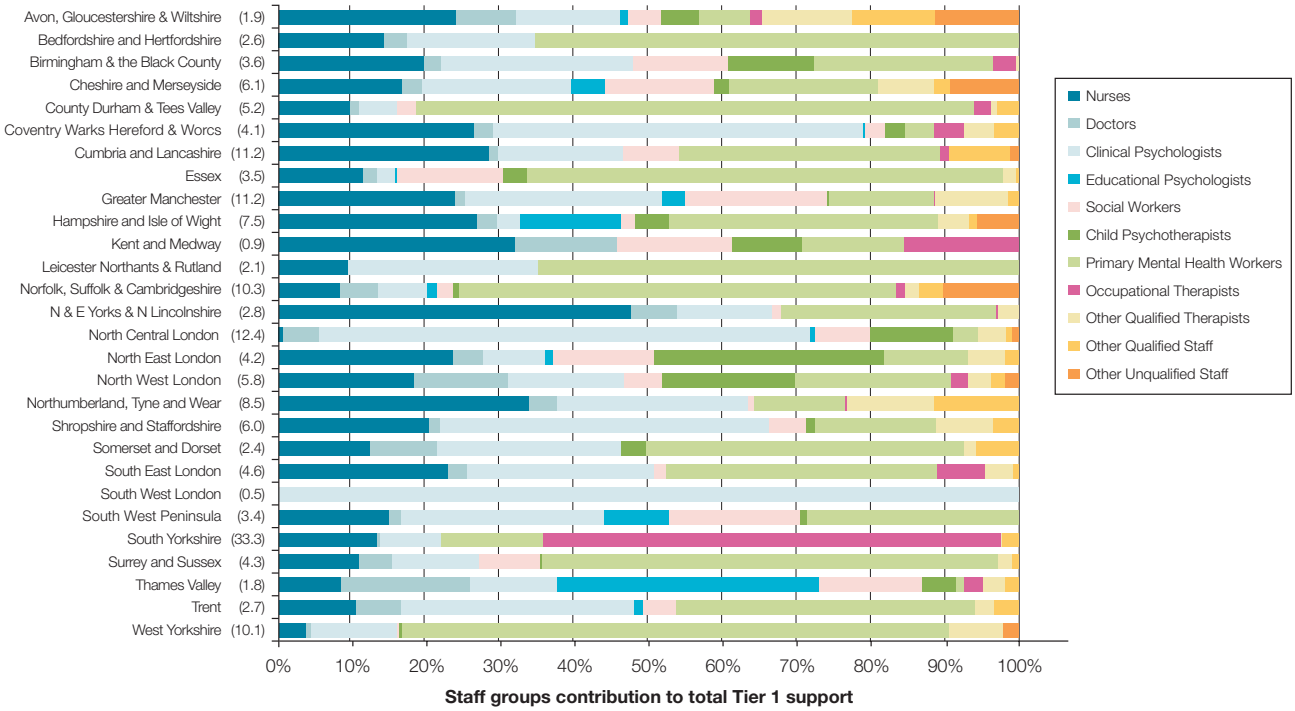


Fig. 5.4b: Workforce Support to tier 1 by SHA

(Numbers after SHA names indicate Tier 1 support WTEs per 100k age 0-17, bar segments indicate proportions provided by staff group)



Primary mental health workers (PMHW) were also asked to identify the amount of their time that was spent supporting tier 1 in community rather than specialist CAMHS settings. On average PMHWs reported working 52% of their time with tier 1, but as mapping responses to this question varied from 100% to zero the findings suggest the question may have been misunderstood. Therefore the data may be unreliable and work should be done to clarify the question in the next mapping exercise.

5.5 National vacancy rates

Definition of vacancy:
A vacancy is a funded post which a service is actively seeking to fill.

Similar national vacancy rates were found for all key professions but there was a large variation between SHAs. Countrywide the vacancy rate for nurses was 15.3% of the funded establishment but it ranged from 25% at the highest to below 5%. The vacancy rate for doctors overall was 13.5%, ranging from high twenties to less than 1%. In total five SHAs had vacancy rates for doctors above 20% (Fig. 5.5a).

The overall vacancy rate for clinical psychologists was 14.8%. Again 5 SHAs had rates of over 20% but these were not the same authorities that had the highest doctor vacancies.

Fig. 5.5a: Vacancy rate - all staff

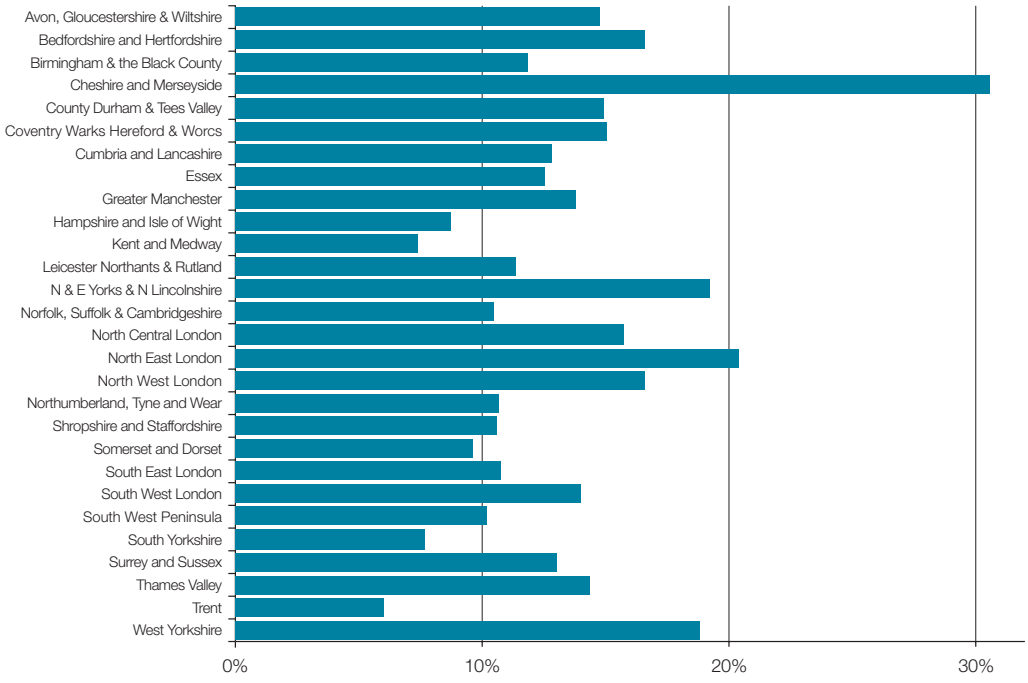


Fig. 5.5b: Vacancy rates for selected staff groups

Chapter 6:
Technical notes

This annex provides an outline of the CAMHS mapping methodology is provide. It covers:

6.1 Basic mapping concepts

Key characteristics of CAMH service mapping include:

- Annual data collection
- A 'service' (CAMHS NHS provider) as the unit of data collection
- Services cover a defined geographical area for local provision, usually individual or groups of PCTs or local authorities
- Includes specialist CAMHS only, covering tier 2 to 4 provision
- Includes all relevant CAMHS provider agencies to reflect local partnerships
- Describes services in terms of 'teams', or units of service delivery
- Separate data collection for expenditure on CAMHS
- All data publicly available through the internet.

6.2 Brief description of data collection process

- Introductory roadshow and telephone/email helpdesk provided throughout collection period
- CAMH Services identified by Strategic Health Authorities
- Local head of service nominated for each 'service' to take responsibility for data returns
- Local head of services reviews data submitted in previous year, revising the list of teams and commissioners as required
- Local head of service ensures commissioners can access the website and return the data requested
- Head of service either completes team data or 'delegates' completion to the team manager
- Data are collected on-line through the Internet
- Data are checked and confirmed correct by chief executives
- Data are frozen on end date (28th February 2005) - no further changes accepted.

6.3 Changes from 2003

- Individual staff questionnaires dropped
- Commissioners reported and signed-off investment data directly
- Previous years data presented as a starting point
- Entry of detailed data delegated to team managers and commissioners
- Caseload data collected for teams not individual staff
- New question indicating whether teams appearing for the first time were new or just previously unmapped.

6.4 Checks and reliability

- Website automatically screens data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered signed off by local chief executives
- Data scrutinised by Durham team during preparation of atlas and performance indicator tables; problems checked with local informants.

6.5 Relationship to Healthcare commission performance indicators

- An important aspect but not the whole purpose of the mapping
- Key data source for four indicators
    - Increased staff
    - Increased investment
    - Increased activity
    - Quality of mapping
- Healthcare commission data frozen at the 28th February –subsequent data cleaning done for Atlas.

Annex 1:

Definitions of Tiers 1,2,3 and 4

Mental health services for children and adolescents have been described according to a four-tier framework as set out in “Together we stand” (HAS 1995)

Tier 1

The phrase primary care is used to describe agencies that offer first-line services to the public and with whom they make direct contact.

This includes interventions by:

- GPs
- Health visitors
- Residential social workers
- Family aides, carers and support workers offer various types of assistance that help to prevent family breakdown.
- School nurses
- Teachers
- Juvenile justice workers

All of these primary care workers regularly encounter early manifestations of difficulty, problems and disorder in children. Complex and serious problems require immediate referral to Tier 2 or 3 (specialist) level of CAMHS. The bulk of more minor problems is, and should be, handled within the primary care sector through discussion, and counselling.

Role of **Primary Mental Health Workers (PMHWs)**: PMHWs are tasked with supporting and enabling Tier 1 professionals and improving the links between the primary and specialist tiers of service. These professionals would need to be integrated into a specialist community CAMHS.

The roles of PMHWs include:

- identifying mental health problems early in their development – early intervention
- offering general advice – and, in certain cases, treatment for less severe mental health problems
- pursuing opportunities for promoting mental health and preventing mental health problems.

Tier 2

A level of service provided by professionals working on their own who relate to others through a network rather than within a team:

- Clinical child psychologists
- Child psychiatrists
- Educational psychologists
- Paediatricians – especially community
- Community child psychiatric nurses or nurse specialists.

Tier 2 services offer:

- training and consultation to other professionals (who might be within Tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs where children or families are unwilling to use specialist services
- assessment which may trigger treatment at this level or in a different tier.

The purpose of tier 2 services is to:

- enable families to function in a less distressed manner
- enable children and young people to overcome their mental health problems
- diagnose and treat disorders of mental health
- enable children and young people to benefit from their home, community and education,
- enable children, young people and their families to cope more effectively with their life experiences.

Tier 3

A specialist service for the more severe, complex and persistent disorders. Because of the complexity of the work that they undertake, staff usually work in a multidisciplinary team or service working in a community child mental health clinic or child psychiatry outpatient service. Tier 3 services might have input from the following professionals:

- Social workers
- Clinical psychologists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists.

In addition to those of Tier 2, the tasks of Tier 3 services are:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in Tier 2 because of the complexity, risk, persistence and interference with social functioning and normal development, and the consequent need for specialist skills.
- To act as gatekeepers, with clearly agreed criteria, for the assessment for referrals to Tier 4.
- To have relationships which ease the passage of children and young people into such care
- To contribute to the services, consultation and training at Tiers 1 and 2
- To ensure smooth transition of individual cases or families to Tiers 2 and 1 before completion of the involvement of Tier 3 service
- To participate in research and development projects.

Tier 4

Tier 4 should be seen as part of a continuum of care for clients and families. They are essentially tertiary services such as day units, highly specialised outpatient teams, and inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk.
Tasks undertaken in Tier 4 involve:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in Tier 3 because of their complexity, risk, persistence and interference with social functioning and normal development, consequently requiring very specialised skills.
- Provisions of interventions that require such a level of skill.
- Provision of services that would not be cost effective in every locality because of sporadic demands for them in smaller populations.
- Provide support to staff working in Tiers 1, 2 and 3, where they are engaged in complex cases that might otherwise require management in Tier 4.

Sources:
Health Advisory Service (1995) Together we stand. London: HMSO
Audit Commission (1999) Children in Mind. London: Audit Commission.

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